MARYLAND MEDICAID

SECTION 1115 HEALTH CARE REFORM
DEMONSTRATION PROPOSAL

August 2005

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A. The Environment

1 Introduction

1.1 The Department of Health and Mental Hygiene (DHMH) is proposing to create a new Medicaid program, called CommunityChoice, to manage services for older adults and people with disabilities. This program will initially pilot in two areas of the State. The program will be mandatory for people who live in the service areas and are eligible for both Medicaid and Medicare (the dual eligibles), other Medicaid beneficiaries aged 65 and over, and other individuals in need of long term care services. The CommunityChoice program will include primary, acute, and long term care services, with a goal to coordinate Medicare funding for dual eligibles.

1.2 The need to restructure Maryland's current long term care system is due to:

1.2.1 Existing fragmentation in the State's health care delivery system. Today, people receive different services across many programs, agencies, and departments. CommunityChoice will streamline this situation and hold one organization (a community care organization, or CCO) accountable for providing and coordinating quality services;

1.2.2 Heavy reliance on institutions to deliver the majority of long term care services;

1.2.3 The escalating cost of long term care, which is a primary component of Medicaid spending growth.

1.3 This project strives to coordinate Medicaid and Medicare funding streams; promote home and community-based services; streamline long term care eligibility determinations; develop and integrate new quality management systems; create integrated networks of care at the local level; and develop an appropriate risk-adjusted reimbursement method that will include incentives for increased community living arrangements.

1.4 Maryland has implemented two home and community-based services waivers to provide opportunities for older adults and adults with physical disabilities to obtain care in their communities. Currently, approximately 3,500 older adults and persons with disabilities are enrolled in these waiver programs. The CommunityChoice program will allow Maryland to move toward an *entire system* of long term care that is predicated on receiving supports in the most suitable integrated setting.

2 Goals and Objectives

2.1 The CommunityChoice program is intended to achieve the following outcomes:

1) Promote community-based long term care services. Over the last few years, Medicaid has expanded home and community-based services through 1915(c) waiver programs. However, those services are still only available to a limited number of enrollees under very specific conditions and limitations. A new model of delivering services can create flexibility to offer cost-effective community services in the least restrictive setting to a greater percentage of Medicaid beneficiaries. Financial incentives to develop alternatives

to nursing facility care will help support the State's *Olmstead* objectives, expand the array of services available to people who need long term care, allow people to age in place, and expand opportunities for consumer direction.

2) Manage all health care costs. The current system pays providers for providing specific services. There are no financial incentives for helping people stay healthy and independent. By changing the financing of services, we can create incentives to promote health, prevent the need for hospitalizations and nursing facility placements, and reduce the rate of growth in Medicaid expenditures by using cost-effective means of care.

3) Coordinate care and establish accountability. By integrating the financing of health care services, CCOs can help Medicaid recipients and their families navigate the maze of services, linking primary, acute, long term care, and social support services while increasing participant satisfaction. Each CCO will be accountable for delivering high-quality services, consistent with consumer direction.

3 Medicaid Managed Care in Maryland

3.1 HealthChoice Program

Since 1997, Maryland Medicaid has operated a mandatory managed care program called HealthChoice. Eligible Medicaid recipients enroll in a managed care organization (MCO) of their choice and select a primary care provider to oversee their medical care. Operated under separate 1115 waiver authority, HealthChoice serves over three-fourths of Medicaid enrollees.

3.2 In 2002, DHMH completed a comprehensive evaluation of HealthChoice. Through focus groups, surveys, and analysis of administrative data, DHMH found that:

3.2.1 *HealthChoice has helped more people access health care services overall*. Access to care improved in many areas such as ambulatory care, well-child visits, and substance abuse treatment.

3.2.2 *HealthChoice serves a much larger and different Medicaid population than before and was the platform for a major program expansion.* One reason these program expansions were possible is that MCOs generally pay higher rates to physicians than in the fee-for-service Medicaid program. On account of the low Medicaid physician fee schedule and provider participation levels, it is questionable if the previous fee-for-service system would have been able to support the major program expansions that occurred, particularly in the Children's Health Insurance Program.

3.2.3 *Overall, the program saved money relative to what would have been spent on fee-for-service*. HealthChoice meets the two federal cost-effectiveness requirements, the federal upper payment limit and the budget neutrality cap, meaning that the program costs less than what services would have cost on a fee-for-service basis. DHMH achieved savings by using risk-adjusted rate setting methods, a process which allocates funds to the participating MCOs according to the health care needs of their enrollees.

3.3 Although CommunityChoice will differ in important ways, this comprehensive evaluation of the HealthChoice program reinforces our belief that capitation and management of care is an effective model for delivering health care services in Maryland. We continue to monitor HealthChoice performance, and access and utilization continue to improve.

4 History of Long Term Managed Care Reform in Maryland

The concept of managed care for dual eligibles is not new to Maryland. In fact, over the last eight years, there has been considerable interest, commitment, and deliberation regarding managed long term care and managed care for dual eligibles in Maryland. In 1996 and 1997, DHMH worked with stakeholders and legislative leaders to develop plans for a managed care program for dual eligibles. Subsequently, HCFA (now CMS) funded planning grants for Maryland to develop a social HMO program for dual eligibles and a capitated program for working age adults transitioning out of nursing facilities. Although these efforts did not lead to the implementation of new programs, they helped develop a knowledge base among advocates, providers and government agencies.

DHMH has also funded a PACE site in Maryland since 1996. Although the CommunityChoice model will differ from PACE in important ways, our experience with PACE suggests that capitated payments and managed care can help promote person-centered health care, prevent institutionalization, and lead to positive health outcomes.

5 Research Findings and Experiences in Other States

Several states operate programs based on principles similar to those in the proposed CommunityChoice program. Researchers have studied these capitated programs that serve older adults and people with disabilities. Taken on the whole, their findings suggest that the CommunityChoice program has great potential to improve access to home and community-based long term care services, improve coordination of services, improve satisfaction, and reduce the rate of growth in Medicaid expenditures. Selected research findings are presented below.

5.1 Minnesota Disability Health Options (MnDHO). MnDHO is a program for working-age individuals with physical disabilities who are dually eligible or only eligible for Medicaid living in the Minneapolis-St. Paul area. In 2004, the Center for Health Care Strategies, Inc. (CHCS) evaluated the effectiveness of the program specifically in the areas of consumer satisfaction, promoting well-being and meeting cost and utilization goals. The evaluation was based on survey and focus group data. CHCS collected data on three topics: overall satisfaction, experiences with health care coordination and self-direction in health care. Some relevant findings of the study are that 89 percent of respondents reported higher overall satisfaction with their health care a year after their enrollment and 94 percent of respondents reported being involved in their plans of care a year after their enrollment (although only 35 completed the one-year follow-up survey).

5.2 Arizona's Long Term Care System (ALTCS). Since 1989, Arizona has operated a mandatory managed care program for individuals who require nursing facility level of care.

5.2.1 In a study by Nelda McCall that compares elderly and physically disabled beneficiaries in ALTCS to a similar population in the fee-for-service (FFS) Medicaid program in New Mexico, it was found that the FFS beneficiaries had more inpatient admissions and more inpatient days as compared to ALTCS enrollees. In addition, when compared with traditional Medicaid, ALTCS beneficiaries pattern of use shows greater use of evaluation and management services but lower use of hospital services. [1]

5.2.2 In 1997, Weissert et al, found that ALTCS achieved considerable savings by substituting home and community-based services for nursing facility care. [2]

5.3 Texas STAR+PLUS is a Texas Medicaid pilot program, started in November 1997, designed to integrate delivery of acute and long term care services through a managed care system. The program serves approximately 63,300 Supplemental Security Income (SSI) and SSI-related aged and disabled Medicaid recipients in Harris County (Houston).

5.3.1 In 2003, the Lewin Group prepared an actuarial assessment on Medicaid managed care expansion options for the Texas Health and Human Services Commission. In the assessment, Lewin cited a report prepared by Dr. Sema Adede of the Institute for Child Health Policy. Her report entitled "The Impact of Care Coordination on the Provision of Health Care Services to Disabled and Chronically Ill Medicaid Patients," found that the STAR+PLUS model achieved a 22.2 percent reduction in inpatient admission volume in Harris County and that enrollees utilized 38.5 percent fewer emergency room visits than the demographically equivalent fee-for-service control group. Even though the population in STAR+PLUS differs in some ways from the proposed CommunityChoice population, the Lewin report demonstrated that long term managed care can lead to significant savings. In this report, Lewin projected that there would be significant cost saving opportunities through expanding the role of managed care in the Texas Medicaid program.[3]

5.3.2 In 2002, the Public Policy Research Institute at Texas A&M conducted an independent assessment of the Texas STAR+PLUS program. The study measured the impact of the program on access to care, quality of care and cost effectiveness. The study used member and provider satisfaction surveys, utilization data, member complaints, costs incurred under the program, and projected costs for the same period had the waiver not been in effect. The program was found to have lowered the rate of inpatient hospitalizations as compared to before implementation.

[1] "Utilization of services in Arizona's capitated Medicaid program for long term care beneficiaries-Patient Centered Care." McCall, Nelda. *Health Care Financing Review.* 1997.

[2] "Cost Savings from Home and Community Based Services: Arizona's Capitated Medicaid Long Term Care Program." Weissert et al. *Journal of Health Politics, Policy and Law*, Vol. 22, No. 6, December 1997.

[3] "Actuarial Assessment of Medicaid Managed Care Expansion Options." The Lewin Group (2004).

5.3.3 The assessment included a focused study on depression which found that there was a significant increase in primary care physicians referring patients to behavioral health specialists as compared to before project implementation. Data provided by the Texas Department of Health Services to PPRI showed that there were significant savings in Harris County over the two years of the program's implementation.[4]

5.4 Private HMOs operating under dual capitation rates in Maryland. In 2002, Burton et al compared clients from a private, for profit managed healthcare organization providing services under capitation rates from both Medicare and Medicaid to a closely matched group of dually eligible older adults receiving care under a fee-for-service plan. This managed health care organization used a method of care that emphasizes prevention by using nurse practitioners in a clinic setting, community primary care physicians and for qualifying persons, adult medical day care for better surveillance of medical problems. The study showed that the HMO's patients had similar health status, better functional status and greater satisfaction with access to care. They received more primary care and preventive services and had fewer hospital days. The lower number of hospital days could be attributed to the use of preventative services and better surveillance of patients.[5]

5.5 Some studies have demonstrated mixed results in managed long term care programs. For example, in 2003, Kane et al found that there were few significant differences over time between a sample of Minnesota Senior Health Options (MSHO) and two control groups. However, the authors concede that this can be attributed to many reasons such as a lack of baseline data taken before the survey or that better coordinated care may not necessarily lead to a decline in sickness or pain due to the nature of this population. On the other hand, the authors did cite that individuals and their families played a much greater role in their care planning and that the program was able to reduce the burden placed on families.[6]

Table 1. Integrated Programs in Other States

States	Target Population	Services	Year Implemented
Arizona – Arizona Long Term Care System (ALTCS)	Dual eligibles and Medicaid-only: Elderly and individuals with physical or developmental disabilities who meet nursing facility level of care standards	Home and community-based services, nursing facility, acute care, pharmacy, mental health	1989

[4] "Medicaid Managed Care Waiver Study: An Independent Assessment of Access, Quality and Cost-Effectiveness of the STAR+PLUS Program," Borders et al.; June 2002, Public Policy Research Institute, Texas A&M University.

[5] "Health Outcomes and Medicaid Costs for Frail Older Individuals: A Case Study of a MCO versus Fee-for-Service Care." Burton et al. American Geriatrics Society. 2002.

[6] "Outcomes of managed care of dually eligible older persons." Kane et al., (2003); Gerontologist-. Apr 2003; Vol. 43 (No. 2): p. 165-174.

Table 1. Integrated Programs in Other States

States	Target Population	Services	Year Implemented
Florida-Community-Based Diversion Pilot	Dual eligibles: Elderly meeting nursing facility level of care standards	Home and community-based services, nursing facility	1998
Texas (Harris County) – STAR+PLUS	Dual eligibles and Medicaid-only: Elderly and individuals with mental or physical disabilities	Home and community-based services, acute care, mental health	1997
Massachusetts – MassHealth Senior Care Options	Dual eligible seniors (65 and older) and seniors eligible for Medicaid.	Medicare Part A and Part B services and those in Medicaid covered services: home and community-based services, nursing facility, acute care, pharmacy, mental health	2004
Minnesota-Minnesota Senior Health Options (MSHO)	Dual eligibles and Medicaid-only: Elderly	Home and community-based services, acute care, hospitalization, 180 days of nursing facility care, pharmacy, mental health	1997
Minnesota (Minneapolis-St.Paul)-Minnesota Disability Health Options	Working-age Medicaid-eligibles with physical disabilities, with or without Medicare	Home and community-based services, nursing facility, acute care, hospital care, personal care attendant services, and transportation (no pharmacy)	2001
New York- Managed Long Term Care Plans and the Continuing Care Network Demonstration	Dual eligibles and Medicaid-only: Individuals meeting nursing facility level of care	Home and community-based services, nursing facility, pharmacy	2002
Wisconsin-Partnership Program	Dual eligibles and Medicaid-only: Elderly and individuals with disabilities meeting nursing facility level of care	Home and community-based services, nursing facility, pharmacy	1999

B. Program Administration

1 Introduction

1.1 This chapter describes the administration of the waiver. It describes how the current Medicaid administrative infrastructure will adapt to meet the new challenges of implementing the waiver. It also describes the relationships between Medicaid and other agencies. Finally, it describes contractual relationships that will affect the implementation of the waiver.

1.2 The CommunityChoice program will differ from HealthChoice in important ways. However, through administering HealthChoice, DHMH already has years of experience with several of the tasks necessary to operate any capitated managed care program. For example, DHMH already:

1.2.1 Contracts with managed care organizations to serve Medicaid recipients. Seven managed care organizations operate in the HealthChoice program.

1.2.2 Contracts with an enrollment broker. The enrollment broker is an independent entity that performs outreach and helps Medicaid beneficiaries choose an MCO.

1.2.3 Develops capitation rates and makes monthly capitation payments. In the HealthChoice program, DHMH makes over $1 billion in risk adjusted capitation payments each year.

1.2.4 Monitors MCO quality. The Department oversees an extensive system for evaluating and improving MCO performance, including value based purchasing, external quality review, consumer satisfaction surveys, HEDIS measures, consumer report cards, and other initiatives.

1.2.5 Collects and evaluates encounter data. The Department collects encounter data to analyze service utilization trends for managed care enrollees.

1.2.6 Provides a mechanism for accepting and responding to consumer questions and complaints. DHMH operates a hotline for HealthChoice recipients. The hotline handles over 100,000 calls per year (95 percent of them are inquiries, rather than complaints).

1.3 In addition to building on existing experience and program capacity, DHMH will devote new resources to administering non-medical support functions for people with disabilities and older adults.

2 Current Maryland Medicaid Administrative Structure

2.1 The Department of Health and Mental Hygiene is the single state Medicaid agency. Within DHMH, the Deputy Secretary for Health Care Financing along with three administrations - the Office of Health Services, the Office of Operations, Eligibility and Pharmacy, and the Office of Planning and Finance – oversee the Medicaid program.

2.2 Each office is responsible for different aspects of the current Medicaid program. Under the waiver, many current activities of each office will continue, albeit with appropriate modifications. A brief description of each administration and some of their activities is presented below.

2.2.1 Office of Health Services. OHS is responsible for developing and codifying Medicaid policies. Examples of major OHS functions include:

- Development and promulgation of regulations;
- Preparation and submission of State Plan amendments;
- Administering fee-for-service and capitated Medicaid programs, including the HealthChoice program, nursing facility program, home and community-based services waivers, etc.;
- Operating the HealthChoice hotline and monitoring MCO quality assurance, including the use of a contract with an external quality review organization;
- Monitoring the quality of care in home and community-based services waivers;
- Oversight of medical eligibility procedures; and
- Developing instructions for the Office of Operations, Eligibility and Pharmacy to use in making programming changes necessary to implement new programs or amend existing ones.

2.2.2 Office of Operations, Eligibility and Pharmacy. OOEP is responsible for Medicaid's day-to-day interactions with recipients and service providers. Examples of major OOEP functions include:

- Maintaining MMIS-II;
- Processing encounter data;
- Making Medicaid capitation payments;
- Processing fee-for-service claims;
- Overseeing eligibility policy and training;
- Maintaining recipient and provider eligibility files;
- Enrolling Medicaid providers; and
- Administering multiple pharmacy programs.

2.2.3 Office of Planning and Finance. OPF is responsible for the fiscal oversight of the Medicaid program. Examples of major OPF functions include:

- Developing the annual Medicaid budget;
- Tracking total Medicaid expenditures against budget projections;
- Setting capitation rates for the HealthChoice program;
- Supporting policy development and evaluation; and
- Monitoring program integrity.

3 DHMH Administrative Units

3.1 The Mental Hygiene Administration is a component of DHMH that reports to the Deputy Secretary for Public Health. The MHA is responsible for overseeing the system for

delivering specialty mental health services to Medicaid recipients and will continue this role for CommunityChoice enrollees. The Public Mental Health System, not the CCOs, will be responsible for coordinating and providing these services to CommunityChoice enrollees. The Medicaid program will collaborate with MHA on the Next Generation Managed Care Project.

3.2 The Office of Health Care Quality is the component of DHMH responsible for licensing and inspecting many types of providers, including adult medical day care centers, assisted living facilities, community mental health programs, home health agencies, hospitals, and nursing facilities. Under CommunityChoice, the OHCQ will maintain its role licensing and inspecting providers while the Medicaid program oversees and monitors CCOs.

3.3 Local health departments are administrative units of DHMH. Local health departments currently perform multiple functions in the Medicaid program, including administration of transportation and personal care benefits and evaluations and assessments for people who need long term care services. Under CommunityChoice, the local health departments will assist with assessments and medical evaluations and may perform oversight and certain quality assurance functions. They will also continue to administer benefits to Medicaid beneficiaries who are not enrolled in CommunityChoice.

4 Administrative Functions Under the Waiver Program

4.1 There are several new tasks required for proper administration of the new program. The tasks fall in to several broad areas:

- CCO qualification review;
- External CCO quality assurance oversight;
- Administrative and financial monitoring of CCOs;
- Eligibility, outreach, and enrollment;
- Program policy and planning; and
- Management information and data systems.

4.2 Sections 4.3 through 4.8 discuss the specific tasks associated with each of these categories.

4.3 <u>CCO qualification review.</u> This function will be led by OHS with involvement by OPF and OOEP.

4.3.1 Participating CCOs will have to meet standards before being allowed to participate in the program. These standards will be set forth in regulations.

4.3.2 The CCO qualifications review process will address capability according to several major areas. The areas include:

- CCO capacity and network adequacy;
- Data systems;
- Clinical and care coordination expertise;
- Augmented community support service expertise;

- Human resource and in-service training expertise;
- Financial and administrative systems; and
- Quality assurance systems.

4.3.3 MCOs that participate in the HealthChoice program will not automatically qualify for the CommunityChoice program. Likewise, holding a certificate of authority as an HMO from the Maryland Insurance Administration will not be sufficient proof that an organization is suitable to participate.

4.3.4 The UMBC Center for Health Program Development and Management will assist DHMH in reviewing CCO applications. DHMH will make the final decision as to whether or not an organization meets the qualifications.

4.4 External CCO quality assurance oversight. This function will be the responsibility of the Office of Health Services. Specific activities include:

4.4.1 Establish and regularly update clinical standards, including standards for different populations. These standards will be developed prior to the start of the program, and be updated thereafter as necessary.

4.4.2 Analyze encounter data and assess CCO clinical performance. Medicaid performance measures are discussed in Chapter J, Quality.

4.4.3 Perform focused studies. Focused studies using chart reviews will help to assess CCO performance in areas that cannot be evaluated using encounter data.

4.4.4 Operate an enrollee hotline, and oversee the ombudsman program and appeals process. The enrollee hotline will provide immediate access to help for enrollees encountering difficulties with their CCO, and will provide DHMH with real-time information to identify problems. Hotline workers will answer questions or solve relatively simple problems, such as difficulty in getting appointments or how disenrollment/re-enrollments are carried out. Complaint resolution staff will resolve disputes about access to care and CCO denials of service. Complaint resolution staff will refer issues needing hands-on recipient education and follow-up to an ombudsman program. Enrollees also may use a formal appeals process.

4.4.5 Conduct enrollee satisfaction surveys. DHMH will conduct enrollee satisfaction surveys across the Medicaid population to allow comparisons of CCO performance. Currently, DHMH uses Consumer Assessment of Health Plans Study (CAHPS) surveys in the HealthChoice program. The population served by the CommunityChoice program will require new questions and new methodologies to ensure adequate response rates. For example, DHMH and its State partners will include a component for peer-to-peer assessment. Where appropriate, DHMH and its State partners will also survey the satisfaction of people who represent CommunityChoice enrollees that may be unable to respond to a survey because of advanced dementia or other causes.

4.4.6 Conduct provider satisfaction surveys. The State will conduct provider satisfaction surveys to provide an additional source of information concerning CCO performance.

4.4.7 Operate a provider hotline. DHMH will operate a provider hotline that will serve as a monitoring tool to help identify and resolve problems. DHMH and CCOs will not take any punitive action against providers and care coordinators for making complaints or appeals against CCOs or DHMH.

4.4.8 Develop and disseminate CCO report cards. Once a well-developed performance evaluation process is in place, the State will compile the results of the various quality assurance activities into a form that recipients can use and understand in choosing among CCOs.

4.5 Administrative and Financial Monitoring of CCOs. This function will be the responsibility of the Office of Planning and Finance.

4.5.1 Rate setting. Initial CCO rates will be set as a percentage of current Medicaid fee for service payments (the fee for service equivalency). In future years, the Department will analyze encounter data provided by CCOs to make yearly adjustments to rates that reflect the services provided by CCOs and the underlying costs of health care.

4.5.2 Solvency standards. The Office of Planning and Finance will monitor the financial performance of CCOs.

4.5.3 Financial Reports. The Office of Planning and Finance will require CCOs to submit periodic reports, e.g., quarterly, on their financial expenses. These reports should provide enough detail to assist with future rate setting calculations as well as to provide DHMH with timely data regarding what is driving certain expenditure trends by service type, eligibility group, or geographical area.

4.6 Eligibility, Outreach, and Enrollment. This function will be the responsibility of the Office of Operations, Eligibility, and Pharmacy.

4.6.1 Eligibility determinations. DHMH and the Department of Human Resources currently share responsibilities for determining recipient eligibility for Medicaid. DHMH will be responsible for determining whether an eligible individual is covered under the CommunityChoice program.

4.6.2 Recipient Education and Outreach. Beginning prior to program implementation, there will be extensive efforts to educate recipients about their rights and responsibilities under the new system (See Chapter F, Enrollee Rights and Responsibilities). OOEP will contract with an enrollment broker and work with State agencies and local partners such as area agencies on aging and local health departments.

4.6.3 Recipient enrollment. CCOs will not directly enroll their members. Instead, DHMH will contract with an independent enrollment broker. The enrollment

broker will be responsible for informing individuals of their choices, answering recipient questions, and enrolling individuals in the CCO of their choice. Enrollment broker staff will receive training in meeting the needs of people with disabilities and older adults.

4.7 Program Policy and Planning. The CommunityChoice program must keep pace with both the changing health care environment and any new federal requirements. The tasks described below are addressed by OHS and OPF. Specific tasks will include:

4.7.1 Performance based awards and/or sanctions of CCOs. CCOs will be subject to incentives and sanctions based upon their performance.

4.7.2 Waiver updates and modifications. Over the life of the waiver, it is likely that amendments to the original waiver will be necessary.

4.7.3 Analysis of Medicaid System Performance. There will be regular, timely analysis of the performance of each CCO and the overall managed care system.

4.8 Management Information and Data Systems. The successful implementation and management of the waiver process requires sophisticated data and systems support. The tasks described below are addressed by OOEP and OPF.

4.8.1 Making payments to CCOs. Monthly capitation payments will be made to each CCO.

4.8.2 Processing encounter claims. CCO encounter data will be processed on a timely basis.

4.8.3 Validation of CCO encounter data submissions. CCO encounter data will be validated on an ongoing basis.

4.8.4 Data Warehousing and Analysis. The encounter data that will be submitted will be used for various functions, such as analysis of program performance, answers to legislators' questions, and future development of capitation rates. To assure that these activities are done in a timely manner, using consistent and reliable data, a central data warehouse with analytic capacity will be developed.

5 Relationships with other State agencies

5.1 DHMH has well-establish relationships with several State agencies that will be directly or indirectly involved in the implementation of the CommunityChoice program. These State agencies and the nature of their involvement are described below.

5.1.1 Maryland Insurance Administration (MIA). The Secretary of DHMH will consult with the Commissioner of the MIA regarding solvency and financial standards for CCOs.

5.1.2 Department of Human Resources (DHR). The DHR and its local departments of social services establish eligibility of Medicaid recipients under agreement with

DHMH. The DHR also currently administers the 1915(c) *Living at Home: Maryland Community Choices* (CMS Waiver Control #0353.90) waiver and will assist in helping 1915(c) waiver participants who live in the CommunityChoice services areas transition into the CommunityChoice program. DHR will continue administering the *Living at Home: Maryland Community Choices* waiver for individuals not residing in the CommunityChoice service areas.

5.1.3 Maryland Department of Aging (MDoA). The MDoA coordinates services, outreach, information and referral, and ombudsman activities for older adults through Maryland's network of area agencies on aging. The MDoA also currently administers the 1915(c) Older Adults Waiver (CMS Waiver Control #0265.90) and will assist in helping 1915(c) waiver participants who live in the CommunityChoice service areas transition into the CommunityChoice program. The AAAs and two newly formed aging and disability resource centers, called Maryland Access Points, will be essential partners in education and outreach. MDoA will continue administering the Older Adults Waiver for individuals not residing in the CommunityChoice service areas.

5.1.4 Maryland Department of Disabilities (MDoD). The MDoD is the state agency responsible for developing Maryland's *Olmstead* plan and for coordinating policies that affect people with disabilities. The MDoD will be an important partner in monitoring and assessing the impact of CommunityChoice on people with disabilities. MDoD will also play a key role in promoting and evaluating the consumer direction option for personal care.

5.1.5 Health Services Cost Review Commission (HSCRC). The HSCRC sets hospital rates under Maryland's unique all-payer system. It also must approve risk arrangements that hospitals enter into if they become managed care entities or when they bear risk under an arrangement with a managed care entity.

5.1.6 Maryland Health Care Commission (MHCC). The MHCC develops a State Health Plan for facilities and services that forecasts the need for nursing facility capacity to meet future needs in Maryland. This Plan governs the approval of new and expanded nursing facilities under the certificate of need program. The MHCC collects and analyzes data on patterns of nursing facility utilization in Maryland, including demographic characteristics, length of stay, payment source, and limitations in activities of daily living. This database is used by policymakers and nursing facility providers to develop plans for organizing, delivering, and financing the future long term care system. The MHCC also reports on the quality and performance of commercial HMOs, nursing facilities, and hospitals.

6 Contractual Relationships

6.1 DHMH will contract with outside entities when a task requires resources or expertise that DHMH does not possess internally. DHMH anticipates that one contractor in particular will play important roles in waiver implementation, as described below.

6.2 University of Maryland – Baltimore County, Center for Health Program Development and Management

6.2.1 The Center for Health Program Development and Management at the University of Maryland Baltimore County provides administrative services to DHMH under a memorandum of agreement. Funds are appropriated by the Maryland General Assembly to DHMH for the Center's support activities. DHMH pays UMBC for invoices submitted that reflect direct and indirect costs of performing services for DHMH. Payments are made through the Statewide Accounting and Reporting System (STARS).

6.2.2 UMBC provides DHMH with access to expertise in the development of capitation rate and risk adjustment methodologies, data base management, and evaluation and analytic skills. UMBC has performed work for DHMH since 1994. UMBC has played (and continues to play) a significant role in implementing and evaluating the HealthChoice program.

6.2.3 In addition, UMBC currently provides analytic and technical support for several Medicaid long term care programs.

6.2.4 For CommunityChoice, UMBC will perform the functions below, all of which it currently performs for the HealthChoice program.

- CCO qualifications review. DHMH anticipates that several organizations will apply to serve as CCOs. CCOs will not be permitted to accept enrollees until being reviewed and approved. The review includes assuring appropriate provider networks are in place. UMBC will assist DHMH in reviewing applications of organizations to become CCOs.

- Rate setting. UMBC is developing the risk adjustment methodology and capitation rates for the waiver. UMBC will competitively procure the services of an actuary for consulting services to assure actuarially sound rates. UMBC will also work with DHMH to update rates annually.

- Data warehouse and decision support system. UMBC will continue to maintain and utilize Medicaid claims data for analytic purposes to support DHMH. UMBC will also develop and utilize analytic files from CCO encounter data.

- Analysis of encounter data for performance measures. UMBC will work with DHMH on evaluating the performance of the CCOs using encounter data.

C. Delivery System

1 Introduction

1.1 This chapter describes the types of organizations that can participate as community care organizations (CCOs), the process by which entities will qualify to become CCOs, the extent to which we believe CCOs will be available, and how historic Medicaid providers will be integrated into CCOs.

1.2 Care under the waiver will be provided by capitated CCOs. The State will enter into provider agreements with any organizations that meet the qualifications that will be promulgated in regulations, and that agree to accept the capitation rates and conditions for participation established by the State.

1.3 Regulations will require that CCOs be licensed as Medicare Advantage Plans in order to participate in CommunityChoice. An enrollee will be free to choose whether or not to receive Medicare services through the CCO. Enrollment in Medicare Advantage will not affect an enrollee's Medicaid benefit package. A benefit to enrolling in a Medicare Advantage Plan over Medicare fee-for-service is that Medicare Advantage Plans may offer case management for Medicare acute care.

2 Community Care Organizations (CCOs)

2.1 All eligible recipients will be served by CCOs that accept risk.

2.2 CCOs will provide Medicaid services as described in Chapter G, Benefits.

2.3 CCOs may subcontract specified required services to a qualified provider that is licensed or authorized to provide those services.

2.4 There are three major incentives for organizations to participate as CCOs in the new program. The first is the desire to expand or retain market share of Medicaid patients. The second is the hope that organizations will be able to provide services more efficiently and at a lower cost. The third is the organizations' commitment to provide high-quality health services for this target population.

3 Types of Organizations that Can Qualify as CCOs

3.1 Two types of organizations can qualify as CCOs: traditional health maintenance organizations that hold a certificate of authority from the Maryland Insurance Administration (MIA); and managed care systems that are authorized to receive medical assistance pre-paid capitation payments and enroll only Medicaid recipients. Both types of organizations must meet the same high standards relating to quality, access, and data in order to qualify as CCOs.

3.1.1 Health Maintenance Organizations. HMOs hold a certificate of authority from the MIA. Twelve HMOs currently operate in Maryland. Under the waiver, possession of a certificate of authority does not assure that an HMO may become

a CCO. Any HMO wishing to serve Medicaid recipients must first qualify as a CCO by meeting the qualifications standards established in regulations.

3.1.2 Non-HMO CCOs. Organizations that are not HMOs may also qualify as CCOs. The main distinguishing features of these organizations in comparison to HMOs are that they will not hold certificates of authority from the MIA. We expect several non-HMO organizations to seek CCO status. The waiver anticipates three types of non-HMO CCOs:

3.1.2.1 Institution-led networks. Large institutions (e.g., hospitals) are expected to qualify as managed care organizations. Under HealthChoice (Maryland's managed care program for children, families, and individuals with disabilities who are not also covered under Medicare), several hospital-owned managed care organizations currently participate.

3.1.2.2 Community-based systems. Providers that have traditionally served the Medicaid population, specializing in services for the elderly and individuals with disabilities.

3.1.2.3 Medicare Advantage Plans. It is unclear yet whether Medicare Advantage Plans must be licensed in the State of Maryland. If licensure is not required, they will need to seek CCO status in order to provide services in Maryland.

3.1.3 Non-HMO CCOs will still be required to meet solvency requirements established jointly by the Department and the Maryland Insurance Administration.

3.1.4 The same solvency requirements that apply to managed care organizations (MCOs) also apply to CCOs. Any regulations established by the Maryland Insurance Administration that apply to MCOs will also apply to CCOs.

4 Quality Standards for CCOs

4.1 All organizations must meet the same high quality and financial standards before being designated as CCOs and allowed to enroll Medicaid recipients. The current HealthChoice MCOs will not be automatically "grandfathered" into the new program.

4.2 Prior to being designated as a CCO and being permitted to enroll any Medicaid recipients, each organization will undergo a rigorous qualifications review. The standards and requirements will be available to the public no later than eight months before the start of CommunityChoice. The approval process will take no longer than 90 days from the receipt of a complete application. The State will examine each potential CCO's capability in a number of different areas, including:

4.2.1 CCO Capacity and Patient Access. These standards are discussed in Chapter I, Access Standards.

4.2.2 Quality Assurance and Data Systems. These standards are discussed in Chapter J, Quality.

4.2.3 Solvency Standards. CCOs must be actuarially sound and have an initial surplus that exceeds their liabilities by at least $1.5 million. Each CCO shall maintain a surplus that exceeds liabilities in an amount that is at least equal to the greater of $750,000 or five percent of the subscription charges earned during the prior calendar year, not to exceed $3 million. If the CCO is not licensed as an HMO, the initial surplus requirement may be adjusted downward in accordance with standards specified in Health General Article §15-102.4, Annotated Code of Maryland.

4.3 CCOs will be required to serve all eligible recipients. Enrollment will be conducted by the State; CCOs will not be permitted to market directly to recipients.

4.4 Policies will be established on CCOs' organizational structure, including certain staffing requirements (e.g., a medical professional who has expertise in aging or disability issues).

4.5 CCOs will not be allowed to accept enrollees until their provider networks are in place and have been approved by the Department. CCOs must allow enrollees to select any Medicaid-participating nursing facility, guaranteeing nursing facilities a contract with all CCOs. In addition, CCOs must pay at least the Medicaid-established rates for nursing facility services. Nursing facilities cannot selectively contract with CCOs.

5 Availability of CCOs

5.1 The State is in an excellent position to implement this program. Not only does the State believe that CCOs will ultimately be available statewide but that there will also be active competition for Medicaid recipients in every corner of the State. This conclusion is based on several facts.

5.1.1 The State currently contracts with seven MCOs (two of which are also licensed HMOs) to provide services under Maryland's mandatory managed care program, HealthChoice.

5.1.2 One of Maryland's HMOs arranges for the delivery of medical services to Medicare beneficiaries living in the community as well as in long term care facilities.

5.1.3 Several organizations have expressed interest in participating in the CommunityChoice program.

5.2 If there is only one CCO available to serve a particular area, Medicaid recipients will receive services through the fee-for-service program.

6 Responsibilities of CCOs During the Initial Transition Period

6.1 Some enrollees will be covered by Medicaid prior to enrollment in CommunityChoice and regularly receiving disposable medical supplies or on-going services at the time they enroll with a CCO. For many of these individuals, any disruption in services could lead to negative outcomes. Therefore, to ensure that Medicaid beneficiaries transition

smoothly into CommunityChoice, the Department will require that CCOs continue to reimburse providers for any medically necessary services received by an enrollee before the CCO develops a plan. Reimbursement rates paid by the CCO to providers during this period will be based on existing Medicaid fee-for-service rates, unless the provider and CCO have already negotiated different rates.

7 CCO Consumer Advisory Boards

7.1 Each CCO shall establish a consumer advisory board to receive regular input from enrollees.

7.1.1 Family members may also serve on the Advisory Board.

7.1.2 Membership must be representative of the CCOs' current enrollees. For example, if individuals with disabilities account for 80 percent of the CCO's enrollment, then individuals with disabilities should represent 80 percent of their Board membership.

7.2 Each CCO shall submit an annual consumer advisory board report to the Secretary of DHMH, the Secretary of MDoD, and the Secretary of MDoA outlining the activities and recommendations of the consumer advisory board. The report will highlight how suggestions were incorporated into CCOs' operations. Following receipt of the report, the Secretaries may request clarification and further action.

8 Contract Termination Procedures

8.1 CCOs can decide to discontinue their participation in CommunityChoice for any given calendar year by the previous October 1.

8.2 At least 60 days in advance of the changeover date, the Department and the CCO shall cooperate in notifying all affected participants in writing of the date of the changeover and the process by which those participants will continue to receive health care.

8.3 The notice will describe the process for selecting another CCO and will include information the recipient can use to compare the available CCOs.

8.4 The Department's enrollment broker will assist with additional outreach activities to ensure a smooth transition.

8.5 The exiting CCO will assist in the transfer of medical and other records, upon request and at no cost to the participant.

9 Sanctions

9.1 Consistent with BBA, CCOs and their contractors will be accountable to DHMH to meet the terms of their contracts and quality performance standards. CCOs whose performance (or the performance of their contractors) is below established standards may be required to submit corrective action plans and the CCO may be subject to sanctions, including financial sanctions.

9.2 DHMH may impose sanctions on a CCO when the CCO:

- Fails to provide medically necessary CCO-covered services or other elements of an individualized plan of care to an enrollee;
- Imposes premiums or charges on enrollees in excess of what is permitted by DHMH;
- Discriminates among enrollees on the basis of disability, health status, or need for health care services;
- Misrepresents or falsifies information provided to DHMH or CMS;
- Misrepresents or falsifies information provided to an enrollee, potential enrollee, or health care provider;
- Distributes marketing materials that have not been approved by the State or that contain false or materially misleading information;
- Fails to meet the quality strategy standards; and
- Fails to meet any standards established in regulations, transmittals, or procedural documents.

9.3 DHMH may impose sanctions in one or more of the following ways:

- Civil money penalties, in compliance with federal limits;
- Granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll;
- Suspension of new enrollments;
- Suspension of capitation payment;
- Termination of the CCO contract;
- Disqualification from future participation in the program;
- Temporary management; and
- Other sanctions imposed by DHMH.

9.4 DHMH will adopt regulations relating to CCO appeals of sanctions.

10 Program Transition

10.1 Program enrollment will begin with the two pilot service areas. The pilot service areas will have at least two CCOs and the proper consumer protections in place, including appropriate provider networks.

10.2 Enrollment in other geographic areas will occur only after legislative approval to expand.

D. Enrollee Program Participation

1 Introduction

1.1 This chapter will discuss 1) CommunityChoice program participation criteria including Medicaid eligibility and program exemption criteria; and 2) the administrative responsibilities for CommunityChoice eligibility determinations.

1.2 CommunityChoice will coordinate services for older adults and people with disabilities. Therefore, the State will enroll into CommunityChoice most Medicaid eligible individuals who qualify under Medicaid's "aged, blind and disabled" (ABD) criteria.

2 CommunityChoice Program Participation Criteria

2.1 Most individuals who will enroll in CommunityChoice are currently accessing Medicaid services through the fee-for-service system.

2.2 Initially, CommunityChoice will not aim to expand Medicaid eligibility to new individuals; however, Medicaid eligible individuals enrolled in CommunityChoice may be eligible to receive an extended benefit package in a variety of settings. In the future, CommunityChoice will serve as the platform for future Medicaid eligibility expansions to this population.

2.3 Medicaid eligibility rules: Medicaid eligibility rules (including spousal impoverishment) will remain as they are except for the changes described below:

2.3.1 CommunityChoice will include the 1915(c) Older Adults Waiver and the *Living at Home: Maryland Community Choices* Waiver populations.

2.3.1.1 Individuals participating in the Older Adults Waiver and the *Living at Home: Maryland Community Choices* Waiver at the beginning of CommunityChoice will continue Medicaid eligibility under this waiver.

2.3.1.2 Other individuals living in the community who are not otherwise eligible for community Medicaid and meeting the optional categorical financial eligibility standards (income less than 300 percent of SSI) may enroll in Medicaid if they also meet the program criteria for CommunityChoice and meet the nursing facility level of care, subject to slot availability.

2.3.1.3 When CommunityChoice begins serving individuals in a service area, waiver slots for the Older Adults Waiver and the *Living at Home: Maryland Community Choices* Waiver will be divided between the service area and the remainder of the State based on the proportion of individuals enrolled in each of the 1915(c) waivers at the start of CommunityChoice.

For example: During the waiver year before starting CommunityChoice, the State maintains a continuous enrollment of 2,800 individuals in the Older Adults Waiver and 1,000 reside in the pilot service areas. Outside

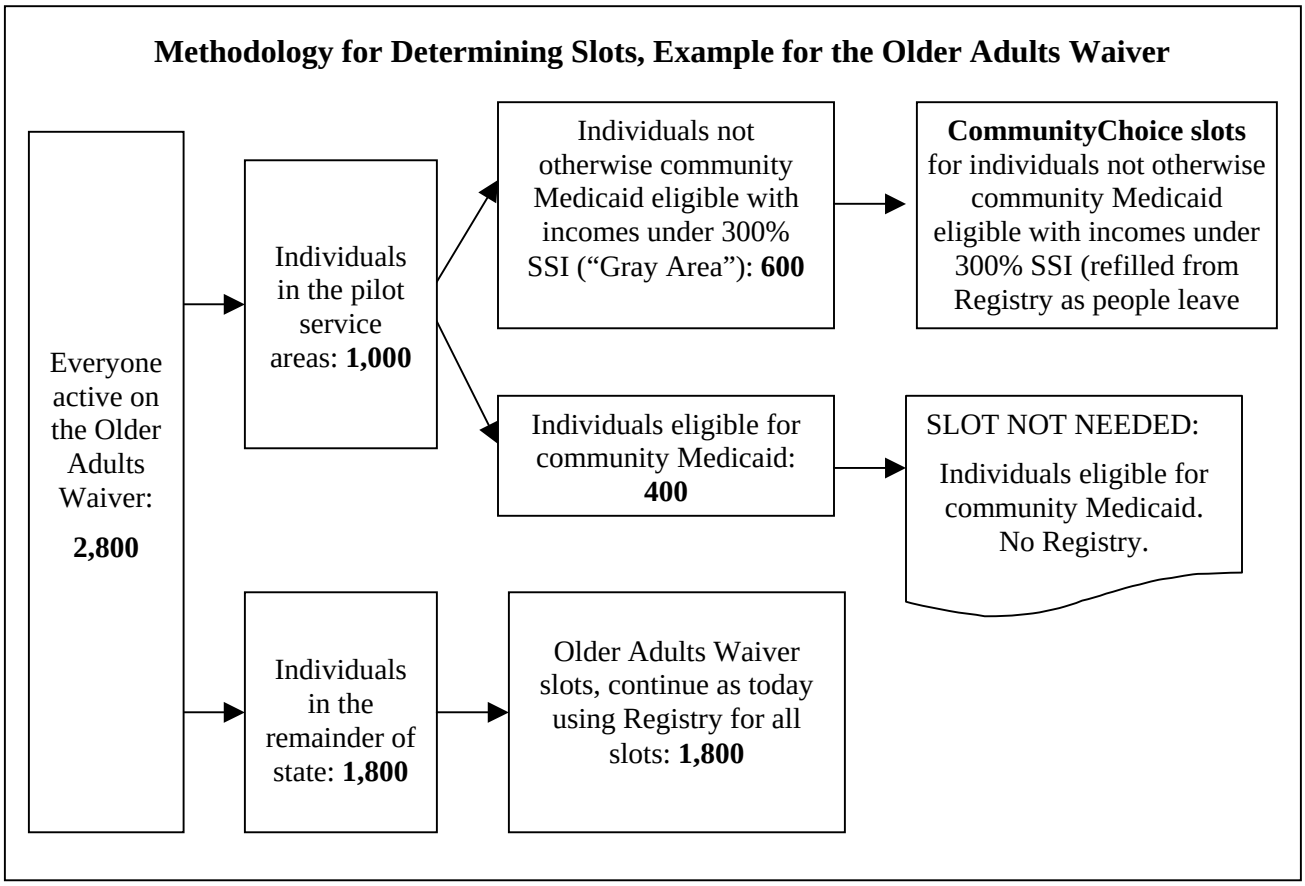
of the pilot service areas, the Older Adults Waiver will maintain an enrollment of 1,800 individuals (2,800 – 1,000 = 1,800).

2.3.1.4 Slots within the CommunityChoice service areas: In order to ensure budget neutrality, DHMH will set the number of slots as the number of "gray area" individuals enrolled in the Older Adults Waiver and the *Living at Home: Maryland Community Choices* Waiver within the CommunityChoice service areas. Gray area individuals are defined as individuals eligible for the 1915(c) waivers who are not otherwise eligible for community Medicaid. They generally have incomes between the Medically Needy Income Level (MNIL) and 300 percent of SSI.

For example: During the waiver year before starting CommunityChoice, the State maintains a continuous enrollment of 2,800 individuals in the Older Adults Waiver with 1,000 of those individuals residing in the pilot service areas. Of those, sixty percent (600 individuals) are not eligible for community Medicaid and are considered "gray area". The State will maintain 600 slots for older Marylanders who are not otherwise community Medicaid eligible and live in the pilot service areas, meet the medical, technical, and financial (generally incomes under 300 percent of SSI) program requirements.

2.3.1.5 Community Medicaid-eligible individuals are not included in the slot count because they will already be enrolled in CommunityChoice. If a community Medicaid-eligible individual meets a nursing facility or chronic hospital level of care, he or she will have access to augmented community support services without needing to apply for a "slot."

The State may increase the number of slots in the future depending on the savings achieved under CommunityChoice.2.3.1.6 The CommunityChoice service areas and the remainder of the state will have separate Waiver Services Registries. Waiting times will be approximately as they are today.



2.3.2 Deinstitutionalized CommunityChoice participants will remain Medicaid eligible in the community as long as the individual continues to meet a nursing facility or chronic hospital level of care:

2.3.2.1 Deinstitutionalized CommunityChoice participants meeting the institutional medically needy eligibility standards (incomes over 300 percent of SSI) may spend down to the income level for the community medically needy (MNIL) based on projected medical expenses in the individual's plan of care.

2.3.3 The medically needy resource level will be equal to the categorically needy resource level.

2.3.4 Disposal of resources look back will be performed for all applicants who are aged, blind, and disabled for the purpose of determining participation in CommunityChoice. The look back will align eligibility rules for community and long term care Medicaid and allow CommunityChoice participants to move seamlessly between housing options.

2.4 Program Participation Criteria: Individuals meeting the following criteria will be enrolled in CommunityChoice:

2.4.1 Individuals must be eligible for **full** Medicaid benefits (Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries do not receive the full Medicaid benefits) on the basis of age, blindness, or disability and reside in a CommunityChoice service area; and at least one of the following:

2.4.1.1 Medicaid recipients age 65 or older; or

2.4.1.2 Receiving Medicare; or

2.4.1.3 Meet a nursing facility or chronic hospital level of care.

2.4.2 Individuals must **not** be any of the following (excluded populations). Individuals not enrolled in CommunityChoice will continue to receive Medicaid benefits as they do today:

2.4.2.1 Under age twenty-one; or

2.4.2.2 Enrolled in the following 1915(c) Home and Community Based Services Waivers:

2.4.2.2.1 The Model Waiver (40118.90),

2.4.2.2.2 Waiver for Individuals with Developmental Disabilities (0023.91) or the New Directions Waiver (0424-IP),

2.4.2.2.3 Waiver for Children with Autism Spectrum Disorder (0339.00),

2.4.2.2.4 Waiver for Individuals with Traumatic Brain Injuries (40198.01); or

2.4.2.3 Enrolled in Programs of All-Inclusive Care for the Elderly (PACE); or

2.4.2.4 Residing in an ICF/MR; or

2.4.2.5 Community eligible based on a spenddown to the income level for the medically needy (MNIL); or

2.4.2.6 Under a penalty for disposal of assets; or

2.4.2.7 Certified for a retroactive period only.

2.5 CommunityChoice participants may be required to contribute towards the cost of care as determined by the Department.

3 Administrative Responsibilities for Eligibility Determination for CommunityChoice

3.1 The Maryland Department of Health and Mental Hygiene (DHMH) is the single State agency designated to administer the Medicaid program in Maryland.

3.2 DHMH, in consultation with MDoA, MDoD, and DHR, will designate local offices to be responsible for determining Medicaid and CommunityChoice eligibility. If a MAP exists in a region, eligibility will be coordinated with the MAP.

E. Enrollment and Disenrollment Process

1 Introduction

1.1 This chapter describes the process by which enrollees and potential enrollees are informed about the CommunityChoice program and processes for CCO enrollment and disenrollment. This chapter also addresses how recipients will be provided with sufficient information on which to base their enrollment decisions. The State, enrollment broker, and CCOs will provide enrollment information (e.g., enrollment notices, informational materials, and instructional materials) to enrollees and potential enrollees in a manner and format that is easily understood.

1.2 The enrollment and disenrollment processes are central to a properly functioning managed care system. The processes in this section are designed to help Medicaid recipients make informed choices and introduce incentives for CCOs to develop recipient-focused systems of care. To function properly, the enrollment process must:

1.2.1 Be unbiased, both in practice and in perception;

1.2.2 Promote informed recipient choice;

1.2.3 Provide useful and accurate information that can be used to make informed choices; and

1.2.4 Must take into account the needs of people with disabilities, older adults, and consumer-directed models of care.

1.3 The Department will use several means to achieve these goals, including intensive outreach and education efforts preceding the program's implementation; the prohibition of direct cold-call marketing by CCOs; and the establishment of an enrollment process that is independent from the CCOs participating in the program.

1.4 Enrollment in CommunityChoice will first occur in the two service areas. Statewide expansion will occur only after legislative approval.

1.5 Each CCO will have in place a mechanism to help enrollees and potential enrollees understand the requirements and benefits of the plan.

1.6 If a recipient does not have the capacity to make decisions about their care, during the enrollment process an authorized representative may help make decisions.

2 Pre-implementation Outreach and Education

2.1 Pre-implementation outreach and education activities will have three goals:

2.1.1 Notify current recipients and potential recipients regarding the upcoming changes to the Medicaid system;

2.1.2 Inform recipients of the effect those changes may have on how they access care; and

2.1.3 Instruct recipients on their rights and responsibilities in a managed care system.

2.2 The Department, in coordination with MDoA and MDoD, will employ a culturally-sensitive public information program to disseminate information about CommunityChoice. Information will be available in ways that are accessible by individuals with disabilities and older adults (e.g., TTY information lines for the hearing impaired, large print for the visually impaired). This will include information about how current Medicaid recipients will choose their new health plan under the program and how most recipients will be able to retain their current providers under the new program. It will also include information on self-direction of personal care services. The public information program will provide general information concerning recipients' rights and responsibilities under managed care. (The principal efforts to educate recipients concerning their rights and responsibilities will occur as part of the enrollment process.) The Department will give special consideration to effectively reach nursing facility residents and their families.

2.3 Potential outlets for the public information program include the DHMH website, face-to-face opportunities such as community meetings and health fairs, direct mailings to potential enrollees, and fliers, newsletters, and brochures. DHMH will hold training sessions for staff of government agencies, community groups, and consumer advocates such as the Senior Health Insurance Assistance Program, centers for independent living, area agencies on aging, local departments of social services, and local health departments, so that they can help educate and answer questions from Medicaid beneficiaries.

3 CCO Marketing Activities

3.1 CCOs may not directly or indirectly engage in door-to-door, telephone, or other cold-call marketing activities (defined as any unsolicited personal contact) with any recipient who is not an enrollee of the CCO, unless authorized by DHMH or the recipient initiates the contact. CCOs may not directly enroll recipients in their plans.

3.2 Subject to prior approval by the Department, CCOs will be permitted to engage in general marketing activities designed to make recipients aware of their availability, as well as any special services they offer. These marketing activities may include media campaigns (such as radio, television, and print) so long as they do not include individual face-to-face solicitation. CCOs must distribute any marketing material to the entire service area.

3.3 Individuals will be able to contact CCOs directly prior to enrolling.

3.4 CCOs may not distribute any marketing materials without first obtaining DHMH approval. In reviewing the marketing materials submitted by the CCO, the State will consult with the Medicaid Advisory Committee.

3.5 CCOs will be required to provide information in a format to be prescribed by the Department that will be used to inform recipients about each CCO, both for the initial enrollment into CCOs and the annual re-enrollment for each recipient. Information to be supplied includes a description of the CCO's provider network, including hospitals, pharmacies, assisted living facilities, medical day care centers, and primary care providers. CCOs will also provide information about any benefits offered beyond those required by the Medicaid program.

3.6 CCOs cannot seek to influence enrollment in conjunction with the sale or offering of any private insurance.

3.7 CCOs will assure the State that marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud recipients or the State agency. Statements that will be considered inaccurate, false, or misleading include, but are not limited to, any assertion or statement (whether written or oral) that the recipient must enroll in the CCO in order to obtain benefits or in order to not lose benefits; or the CCO is endorsed by CMS, the federal or State government, or similar entity.

4 Enrollment Broker

4.1 The Department will contract with an independent enrollment broker to enroll Medicaid recipients into the program. Through Maryland's HealthChoice program, the Department has developed systems and a wealth of practical experience that will now be applied to enrolling recipients into CCOs. (Under HealthChoice, recipients are able to choose their MCOs and primary care providers. Those who do not choose are automatically assigned to an MCO, which then assigns a primary care provider. The HealthChoice enrollment broker has been successful in helping HealthChoice enrollees select their MCOs; over the past two years 81 percent of HealthChoice enrollees have selected their MCOs. Moreover, a high rate of HealthChoice enrollees select their primary care providers; 70 percent of HealthChoice enrollees select and are assigned to their primary care providers during the enrollment process.)

4.2 The enrollment broker will prioritize hiring individuals with disabilities and older adults.

4.3 When individuals are notified of their eligibility for Medicaid, they will be provided an enrollment packet, including necessary forms for enrolling in a CCO and the toll free phone number of the enrollment broker. Potential enrollees will receive information on CCOs in their service area at the time they are first required to enroll in a CCO.

4.3.1 Information provided to potential enrollees by the enrollment broker will include:

- The basic features of managed care;
- The fact that enrollment is mandatory, and that auto-assignment will occur for those who do not choose a CCO;
- CCO responsibilities for coordination of enrollee care; and
- Benefits covered, in sufficient detail for enrollees to understand the benefits to which they are entitled;
- Benefits that are available under the State Plan, but not available through the CCO, including how and where the enrollee may obtain those benefits, any cost sharing, and how transportation is provided;

- For a counseling or referral service that the CCO does not cover because of moral or religious objections, information about where and how to obtain the service;
- A statement of enrollee rights and responsibilities.

The enrollment broker will also include summary information specific to each CCO (with more detailed information available upon request) on:

- Cost sharing;
- Service areas;
- Names, locations, telephone numbers of current contracted providers (such as primary care physicians, specialists, hospitals, assisted living facilities, medical day care centers), including identification of providers that are not accepting new patients and identification of any non-English languages spoken by providers; and
- To the extent available, quality and performance indicators, including enrollee satisfaction.

4.3.2 The enrollment packet will include general information about the key topics in 4.3.1. The enrollment packet will also include information specific to each CCO in the potential enrollee's service area. More detailed information on the key topics in 4.3.1 will be available upon request.

4.3.3 Written materials will be in accessible and easily understood language and format. Information on CCOs will be provided in a comparative, chart-like format. Written information distributed by the enrollment broker and the CCOs will be available in English as well as any other non-English language spoken by at least three percent of the population. In addition, the enrollment broker and CCOs will make available interpreter services for all languages (including sign language) free of charge to enrollees and potential enrollees. The enrollment broker will notify enrollees and potential enrollees, and CCOs will notify their enrollees, that interpretation and non-English language materials are available, and will provide information on how to access interpreter services and non-English language materials.

Alternative formats, such as text documents, will be designed to take into consideration the special needs of those who, for example, are visually limited. The enrollment broker will inform enrollees and potential enrollees that information is available in alternative formats, and will provide information on how to access alternative formats.

4.4 On an individual level, the enrollment broker will provide the most effective means of personal and direct outreach, including face-to-face enrollment when necessary. In addition, the enrollment broker will take a proactive role to provide education and outreach activities at the community level. Recipients will be encouraged to contact the enrollment broker if they have questions. The enrollment broker will be able to answer general questions about the available CCOs, assist recipients in interpreting the CCO informational materials, and assist recipients in contacting CCOs for more specific information about providers and benefits. Individuals may enroll either by mail, by telephone, or in a face-to-face meeting with the enrollment broker if necessary.

4.5 Potential enrollees will have the choice of at least two CCOs. Upon the notification of Medicaid eligibility, recipients will have 60 days in which to select a CCO. Simultaneously, non-dual-eligible individuals will choose a primary care physician. (Dual eligibles will receive primary care services through Medicare.) This 60-day timeframe will enable the beneficiary to use the information provided by the enrollment broker in choosing a CCO. The enrollment broker will follow up with a second notice and telephone call to the potential enrollee (or his/her representative). Potential enrollees who do not choose within this timeframe will be automatically assigned to a CCO.

4.6 Auto-assignment to CCOs will seek to preserve existing provider-recipient relationships and relationships with providers that have traditionally served Medicaid recipients, and will follow the following criteria:

4.6.1 If a recipient is enrolled in a Medicare Advantage plan which also participates as a Medicaid CCO, the recipient will be assigned to that CCO.

4.6.2 If 4.6.1 does not apply and the recipient was previously eligible and enrolled in a HealthChoice MCO (within the last 120 days) that is also certified to participate as a CommunityChoice CCO, he/she will be assigned to that CCO;

4.6.3 If 4.6.1 and 4.6.2 do not apply, he/she will be randomly assigned to a CCO in the service area with available capacity.

4.7 After the recipient has chosen or been assigned to a CCO, the enrollment broker will administer a self-reported health assessment of the enrollee and forward the results to the CCO within five business days. The health risk assessment will help identify those individuals who need special or immediate health care services so that they can receive services on a timely basis. A personal representative or family member may be involved in the completion of the health assessment.

4.8 Once an individual enrolls with a CCO, the CCO will be responsible for providing, within a reasonable time period, the following information:

- How to request and obtain the information in 4.3.1;
- Grievance, appeal, and fair hearing procedures;
- Advance directives policies;
- Procedures for obtaining benefits, including authorization requests;
- Procedures for developing plans of care, including how an enrollee can participate in developing his/her own plan of care;
- Notice of termination of a contracted provider to enrollees who received primary care from, or were seen on a regular basis by the terminated provider. The CCO must make a good faith effort to give written notice within 15 days after receipt or issuance of the termination notice;
- Notification in writing of significant changes to the topics in 4.3.1 at least 30 days before the intended effective date of the change;
- The extent to which, and how, enrollees may obtain benefits from out-of-network providers;

- The extent to which, and how, after-hours and emergency coverage are provided, including what constitutes emergency medical condition, emergency services, and poststabilization services; the fact that prior authorization is not required for emergency services; the process and procedures for obtaining emergency services, including use of the 911telephone system or its local equivalent; the locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and poststabilization services; and the fact that the enrollee has a right to use any hospital or other setting for emergency care;
- The poststabilization care services rules; and
- The CCO's policies on referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider.

4.9 The Department will monitor the performance of the enrollment broker. Particular attention will be paid to the following aspects of the enrollment broker's performance.

4.9.1 Automatic assignments. Automatic assignments mean that recipients have not made an informed choice; therefore, high levels of automatic assignments may indicate poor performance.

4.9.2 CCO disenrollment rates. High rates of disenrollment may indicate that recipients are not being properly informed of CCO features and providers.

4.9.3 Complaints. Complaints from enrollees, CCOs or any other source will be considered in evaluating the performance of the enrollment broker.

5 Re-enrollment and Annual Right to Change

5.1 Upon the annual anniversary of enrollment in a CCO, each enrollee will be given an opportunity to choose a new CCO, or to remain with the current CCO.

5.1.1 The enrollment broker will be responsible for annually providing each enrollee with information about their disenrollment rights and information about each CCO in their service area in an annual right to change (ARC) packet. The ARC packet information will be almost entirely the same as what is provided to potential enrollees in the enrollment packet, and will include a notice to enrollees of their right to request and obtain information outlined in 4.3.1 at least annually.

5.1.2 The enrollment broker will send the annual right to change packet at least 60 days before the start of the enrollee's new enrollment period. As noted above, the ARC packet will notify enrollees about their right to request and obtain information about provider networks, as well as the information in 4.8.

5.2 Recipients will have the month of the anniversary date of their enrollment in a CCO in which to choose a new CCO or to elect to stay in their current CCO. Recipients who fail to make a choice will automatically be maintained in their current CCO.

5.3 Individuals who are disenrolled from a CCO due to loss of Medicaid eligibility will be automatically re-enrolled into the same CCO if they regain Medicaid eligibility within four months or less. Upon automatic re-enrollment, the recipient may change CCOs if the

temporary loss of Medicaid eligibility has caused the recipient to miss the annual opportunity to choose a new CCO.

6 Disenrollment

6.1 As noted in section 4.9, the recipient disenrollment rate will be tracked as a possible sign that recipients are receiving inadequate information during the enrollment process. Some disenrollment, however, is inevitable. Experience with the HealthChoice program has shown that when recipients have satisfactory relationships with a primary care provider they rarely change MCOs.

6.2 Disenrollment Without Cause.

6.2.1 Individuals may disenroll without cause during the 90 days following the date of the recipient's initial enrollment with the CCO or the date the Department sends the recipient notice of the enrollment, whichever is later.

6.2.2 During the first 12 months of the CommunityChoice program, enrollees will be permitted one disenrollment from a CCO and enrollment into another CCO without having to meet one of the conditions specified in section 6.3.

6.3 Disenrollment for cause.

6.3.1 Enrollees may change CCOs if they move to an area that is not served by their current CCO.

6.3.2 Enrollees must disenroll from CommunityChoice if they move to an area of the state not served by CommunityChoice. If an individual/support team/CCO agree that an individual should be placed in a nursing facility or assisted living facility outside of the CCO's service area, the individual's CommunityChoice eligibility shall continue.

6.3.2 Individuals who enroll in a Medicare Advantage plan that also participates as a CCO may change to that CCO.

6.3.3 Enrollees may request a change of CCO at any time upon a showing of good cause. Such requests for changing CCOs will be reviewed, and either approved or denied, by DHMH.

6.3.4 Individuals who lose Medicaid eligibility will be disenrolled.

7 CCO Responsibility to Accept Enrollees

7.1 CCOs must accept all individuals who enroll or who are assigned by the enrollment broker. CCOs may not discriminate on any basis, including but not limited to age, sex, race, ethnicity, religion, national origin, sexual orientation, physical or mental disability, or type of illness or condition.

7.2 A CCO may request that an enrollee be disenrolled for good cause. All such requests will be reviewed and decided by the State. A CCO may not request disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or challenging behavior resulting from his or her special needs (except when his or her continued enrollment in the CCO seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees).

F. Enrollee Rights and Responsibilities

1 Introduction

1.1 This section describes the rights and responsibilities for enrollees in the CommunityChoice program.

2 Enrollee Rights

2.1 Each enrollee is guaranteed the right to:

2.1.1 Be treated with respect and with due consideration for his or her dignity and privacy;

2.1.2 Appoint a representative to act on his/her behalf, consistent with federal and State regulations;

2.1.3 Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand;

2.1.4 Participate in decisions regarding his or her health care, including the right to refuse treatment;

2.1.5 Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion;

2.1.6 Receive information on covered services, how to access services, disenrollment rights, and other features of the CommunityChoice program, as described in Chapter E, Enrollment and Disenrollment Process;

2.1.7 Request and receive a copy of his or her medical and other records and request that they be amended or corrected, as allowed under State and federal privacy rules;

2.1.8 Receive information regarding grievances, appeals, and requests for hearing;

2.1.9 Not be discriminated against in the delivery of health care services on any basis, including but not limited to age, sex, race, ethnicity, religion, national origin, sexual orientation, physical or mental disability, or type of illness or condition.

2.1.10 Have services provided in a culturally competent manner, with consideration for enrollees with limited English proficiency or reading skills, and those with diverse cultural and ethnic backgrounds as well as enrollees with visual, cognitive, or auditory limitations;

2.1.11 Refuse care from certain providers;

2.1.12 Remain in a nursing facility if he/she resides there at the point of enrollment and continues to meet nursing facility level of care, or enter a nursing facility if he/she meets nursing facility level of care;

2.1.13 Be provided with information about advance directives;

2.1.14 Receive covered services in the least restrictive and most integrated environment appropriate to his or her needs, consistent with cost efficiency and the benefits structure described in Chapter G, Benefits;

2.1.15 Be furnished covered services through a network of providers that is sufficient to ensure timely access to quality care;

2.1.16 Freely exercise these rights without adverse treatment from the enrollment broker, providers, CCOs, or the State.

2.2 Each CCO will have written policies regarding enrollee rights in compliance with federal and State laws.

2.3 Each CCO shall ensure that its providers, acting within the lawful scope of their practice, are not prohibited or otherwise restricted from advising or advocating, on behalf of an enrollee who is his or her patient, for:

2.3.1 The enrollee's health status, medical care or treatment options, including any alternative treatment that may be self-administered;

2.3.2 Any information the enrollee needs in order to decide among all relevant treatment options;

2.3.3 The risks, benefits, and consequences of treatment or non-treatment; and

2.3.4 The enrollee's right to participate in decisions regarding his or her care, including the right to refuse treatment, and to express preferences about treatment decisions.

3 Enrollee Responsibilities

3.1 Information from enrollees and their representatives is essential to quality assurance and program integrity. Enrollees or their representatives are responsible, to the best of their abilities, for:

3.1.1 Alerting the Department of any poor performance by providers or by CCOs;

3.1.2 Notifying the CCO or the Department if they suspect a provider is engaged in fraudulent billing practices;

3.2 Enrollees are also responsible, to the best of their abilities, for:

3.2.1 Scheduling appointments during office hours whenever possible instead of using urgent care facilities or emergency rooms;

3.2.2 Arriving for appointments on time;

3.2.3 Notifying a provider in advance when it is not possible to keep an appointment;

3.2.4 Helping the CCO and other professional staff understand the enrollee's goals and desires regarding health care services.

G. Benefits

1 Introduction

1.1 This chapter of the waiver will introduce the guiding principles behind the waiver benefit package and describe the benefits to be provided to CCO enrollees.

1.2 The CommunityChoice program will include a comprehensive benefits package, including primary care, acute care, reproductive health and family planning, substance abuse, transportation, and long term care services. All CommunityChoice enrollees will be entitled to all services covered under Maryland's State Plan, as medically necessary. Two services will be provided through the fee-for-service program – specialty mental health and hospice. For many CommunityChoice enrollees, however, Medicare will be the primary payer for some of their health care services.

1.3 The CommunityChoice program is designed to emphasize home and community-based long term care services ahead of institutional placement. Additional home and community-based long term care services, which are currently available only to participants in our 1915(c) waivers, will be available to all enrollees who require nursing facility or chronic hospital level of care under the 1115 waiver, within individual and overall budget neutrality for the waiver. We refer to these home and community-based long term care services as augmented community support services.

1.4 The CommunityChoice program will not eliminate coverage of existing Medicaid covered services for any enrollees.

2 Benefit Package for CCO Enrollees

2.1 *CCO Benefits Package.* For all enrollees, CCOs will be financially responsible for providing benefits equivalent to the benefit level required by the Maryland Medical Assistance program (as described in the Maryland Medical Assistance State Plan) as determined to be medically necessary, with the exception of limited "carve-outs" described in this chapter. In addition, for enrollees who require nursing facility or chronic hospital level of care, CCOs will be financially responsible for providing augmented community support services (described below) that are determined to be medically necessary, appropriate, and cost effective.

2.1.1 Specialty Mental Health Carve-Out: Enrollees will access specialty mental health services through the Public Mental Health System which is administered by the Mental Hygiene Administration. The Department will reimburse specialty mental health providers under Medicaid-established rates. The Mental Hygiene Administration will continue to fund inpatient services in State Psychiatric Facilities.

2.1.2 Hospice Care Carve-Out: The Department will make payments directly to the hospice provider for hospice care, as described in the Chapter L, Financing. For individuals residing in an institution, the CCOs will be responsible for the room and board portion of the institutional hospice payment.

2.1.3 The Medicaid transportation benefit, which is currently covered as an administrative service through the local health departments, will be the responsibility of the CCO. DHMH and its State partners will work with CCOs to maximize coordination with existing human services transportation programs. Making transportation part of the CCO's benefit package will create a strong incentive to develop robust networks of providers in all parts of the State.

2.2 *Augmented Community Support Services*. These services help accomplish greater independence. They include case management/care coordination; assisted living services (not including room and board); attendant care; environmental assessments; environmental accessibility adaptations; assistive devices/technology; behavioral consultation services; respite care services; personal emergency response systems; consumer and family training; dietician/nutritionist services; Senior Center Plus; transition services; and home delivered meals. Limitations may apply to the duration, amount, or scope of services, consistent with the existing limitations under Maryland's home and community-based services waivers.

2.3 *Optional Services*. The CCO will further have the option of providing an enrollee with any additional services to promote health and independence or help an enrollee transition from an institutional placement to the community.

2.4 *Authorization of services.* A CCO must establish and follow written policies and procedures for deciding whether or not to authorize services.

2.4.1 The CCO must have mechanisms in place to ensure consistent application of review criteria for authorization decisions.

2.4.2 Any decision to deny services, or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

2.4.3 If the Department certifies an enrollee as requiring nursing facility level of care, CCOs must offer any community-based alternatives to nursing facility services that can adequately meet the needs of the enrollee, subject to a cost neutrality test (described below). However, the CCO may not deny nursing facility placement if the enrollee elects it.

2.4.4 The CCO must notify the requesting provider and give the member written notice of any decision by the Program Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must be timely and meet other standards as described in Chapter J, Quality.

2.4.5 Enrollees may appeal any denial of services, as described in Chapter K, Complaints and Appeals.

2.4.6 "Medically necessary" means that the service or benefit is:

- Directly related to diagnostic, preventive, curative, palliative, rehabilitative or ameliorative treatment of an illness, injury, disability, or health condition;
- Consistent with current accepted standards of good medical practice;
- The most cost efficient service that can be provided without sacrificing effectiveness or access to care; and
- Not primarily for the convenience of the consumer, their family or the provider.

2.5 *Cost neutrality test.* In general, for enrollees who require nursing facility level of care, CCOs will be required to offer home and community-based long term care services before institutional services. Enrollees may select either home and community-based or institutional long term care services. However, a CCO will not be required to provide community based long term care services if the cost of serving the enrollee in the community would exceed the cost of nursing facility services for that individual and the CCO takes the following steps:

2.5.1 Before denying community services, the CCO must document that it made a good faith effort to establish a cost effective plan of care in the community.

2.5.2 The cost neutrality test may not factor in the enrollee's projected contribution to the cost of care.

2.5.3 To ensure that the cost neutrality rule is applied fairly and only after all alternatives have been exhausted, the Department will establish a process to automatically review all cases where a CCO denies home and community-based services to an enrollee due to the cost neutrality test. Enrollees may appeal the denial of services based on the cost neutrality test as well as the result of the Department's review.

2.5.4 At the start of the CommunityChoice program, there may be a small number of enrollees who transition into the program from existing 1915(c) waivers or the REM program whose community services marginally exceed the cost neutrality test. In these rare cases, the CCO must continue to serve the individual in the community unless there is a significant change in the individual's needs.

2.6 *Prohibition against requiring residential placements.* A CCO may not require that an enrollee move into an assisted living facility (or other community-based residential placement) solely because the costs of serving the enrollee in his or her own home would exceed the cost of the assisted living services for that individual.

2.7 *Impact on Home and Community-Based Services (HCBS) Waivers*. There are two HCBS waivers in Maryland that currently serve a target population that overlaps with the population to be covered under this demonstration. The two waivers are: 1) the Waiver for Older Adults, and 2) *Living at Home: Maryland Community Choices*. The implementation of this 1115 waiver demonstration will impact both of these programs as explained below. As stated above, the CommunityChoice program will not eliminate existing Medicaid covered services for any enrollees.

2.7.1 Home and Community-Based Services Waiver for Older Adults – The waiver allows for the coverage of community-based services for adults aged 50 and above and who meet nursing facility level of care as an alternative to institutionalization in a nursing facility. Services include personal care (including skilled nursing supervision), assisted living services, environmental assessment and modifications, assistive equipment, behavior consultation, Senior Center Plus, respite care, family or consumer training, personal emergency response systems, and dietician or nutritionist services. Individuals participating in this HCBS waiver who reside in the CommunityChoice service areas will transition into the 1115 waiver and receive services through a CCO.

2.7.2 *Living at Home: Maryland Community Choices* – This waiver allows for the coverage of home and community-based services for individuals with physical disabilities, aged 18 to 59, as an alternative to institutionalization in a nursing facility. Services include attendant care (including skilled nursing supervision), assistive technology, environmental accessibility adaptations, personal emergency response systems, consumer and family training, financial management of self-directed employer services, and transition services for people moving out of nursing facilities. Individuals participating in this HCBS waiver who reside in the CommunityChoice service areas will transition into the 1115 waiver and receive services through a CCO.

3 Cost Sharing Requirements

3.1 For dual eligibles, CCOs will cover any cost sharing requirements when Medicare is the primary payer of services.

3.2 The Department will allow CCOs to charge limited co-payments and other cost sharing for enrollees, in accordance with federal rules. Any cost sharing requirements will be subject to a public regulatory process and will not exceed those in fee-for-service Medicaid.

3.2.1 Pharmacy. For enrollees receiving prescription coverage through Medicaid, CCOs may require that enrollees pay up to a $1 co-payment per generic prescription drug or $3 co-payment per brand-name prescription drug. Nursing facility residents, pregnant women, and hospice recipients are exempt. A pharmacy cannot deny services due to an enrollee's inability to pay the co-payment.

3.2.2 Nursing facility and other institutional long term care services. CCOs may require that enrollees contribute to the cost of their nursing facility and other institutional long term care, subject to the same rules that currently exist in the Maryland Medicaid program. The personal needs allowance for nursing facilities will be $62 per month (for State fiscal year 2006) and be adjusted annually by the percent change in social security benefits.

3.2.3 Assisted living services. CCOs may require that enrollees contribute to the cost of their assisted living services. Each assisted living resident must be permitted to keep a portion of his/her income per month to cover room and board expenses in the amount as defined in regulation (the amount in 2005 is $420). (Current

regulations also allow the assisted living provider to charge up to $420 as room and board cost.) The resident may also keep as a personal needs allowance the same amount as is allowed for nursing facility residents. If the resident has income exceeding the allowances for personal needs and room and board (from sources other than SSI), s/he may be required to contribute to the cost of his or her own care by offsetting some amount of the assisted living costs. These are the same rules that currently exist in the 1915(c) Waiver for Older Adults.

3.2.4 Augmented support services in an enrollee's home. CCOs may require that enrollees contribute to the cost of their home care services only in limited circumstances. Each enrollee receiving non-residential augmented community support services must be permitted to keep his/her monthly income, up to 300 percent of SSI, to cover housing, food, and other expenses. If the enrollee has transitioned from a nursing facility and has income exceeding 300 percent of SSI, s/he may be required to contribute to the cost of his/her own care by offsetting some amount of the costs of Medicaid services.

3.2.5 CCOs will be responsible for collecting (or arranging for the collection) of cost sharing amounts.

4 Continuity of Providers

4.1 Some Medicaid beneficiaries will be regularly receiving disposable medical supplies or on-going services from providers such as personal care aides, medical day care centers, or assisted living facilities at the time they enroll with a CCO. For many of these individuals, any disruption in services could lead to negative outcomes. Therefore, to ensure that Medicaid beneficiaries transition smoothly into CommunityChoice, the Department will require that CCOs continue to reimburse providers for any medically necessary services received by an enrollee before the CCO develops a plan. Reimbursement rates paid by the CCO to providers during this period will be based on existing Medicaid fee-for-service rates, unless the provider and CCO have already negotiated different rates. The enrollment broker will also promote continuity of care by helping potential CommunityChoice enrollees identify which CCOs include their current Medicaid providers in network.

4.2 Nursing facility residents may continue to receive services in the facility they reside in when entering the CommunityChoice program.

4.3 At initial implementation of the CommunityChoice program, assisted living residents and regular participants at medical day care centers will be permitted to stay with their existing facility or center, unless documented quality of care problems exist.

4.4 To the extent practicable, CCOs will allow waiver enrollees who meet the nursing facility level of care, to select a nursing home, assisted living facility, or adult day care center provided that the facility is licensed by DHMH and the provider meets DHMH-approved credentialing requirements of the CCO.

4.5 Other provisions regarding continuity and choice of personal care providers are described in Chapter H, Personal Care and Consumer Direction.

5 Coordination of Care

5.1 Each CCO is responsible for coordinating the services offered under CommunityChoice, and coordinating those services with services covered under Medicare, services covered by other third party payers, and other community supports. This includes appropriate referrals to the Public Mental Health System and coordination with care managers in the Public Mental Health System. Care coordination under CommunityChoice is not only intended to coordinate medical services, but to also support community integration and access to community services.

5.1.1 The CommunityChoice Advisory Group will assist the Department in developing additional details of how CCOs will provide care coordination under CommunityChoice. A subcommittee will also be convened to engage experts on care coordination, case management, and consumer direction.

5.2 For enrollees with a nursing facility or chronic hospital level of care, CCOs will use a comprehensive support team, including the enrollee and their representatives, the care coordinator, the enrollee's primary care provider, nurse manager, and others as appropriate.

Enrollees receiving personal care services will be assigned a care coordinator.

5.3 A care coordinator is a person who is either a degreed social worker, licensed registered nurse, or a person with a minimum of two years experience in providing care coordination/case management services, including relevant experience arranging non-medical support services, to the populations covered under CommunityChoice (older adults and individuals with disabilities).

5.4 CCOs will submit care coordination procedures, care plan criteria, and assessment tools to DHMH for approval.

5.5 The support team/care coordinator must foster a person-centered approach and respect maximum enrollee/family self-determination while promoting dignity, independence, individuality, privacy and choice. Care coordination begins with a respect for the enrollee's and enrollee's family's preferences, goals, interests, needs, values, language, and belief system.

5.6 Enrollees and their representatives shall be recognized as partners in the care planning process. The CCO must permit the enrollee or enrollee's representative to participate in the development or revision of any plans of care. Care plans will be developed using a comprehensive care and support management approach, including participation from the enrollee, enrollee's representatives, the primary care physician, specialists, and community providers, as appropriate.

5.7 For new enrollees, designated members of the support team/care coordinators will be required to initiate phone contact with the enrollee within seven days from the date of the nursing facility level of care determination for enrollees who meet level of care, and within seven days from the date the CCO receives information that an enrollee needs

personal care services. The support team/care coordinators must conduct a comprehensive face-to-face assessment and develop and initiate the care plan within 30 days from the date of the nursing facility or chronic hospital level of care determination for new enrollees who meet level of care, and within 30 days from the date the CCO receives information that an enrollee needs personal care services. Designated members of the support team/care coordinators must be available to provide face-to-face contact as needed.

5.8 DHMH will require designated members of the support team/care coordinators to conduct periodic on-site placement and service reviews. DHMH will require these reviews every 90 days for enrollees living at home or in alternative community-based settings, and every 180 days for enrollees in institutional settings or for enrollees receiving personal care services who do not meet nursing facility level of care. Designated members of the support team/care coordinators may conduct more frequent reviews based on the social and clinical needs of different individuals.

5.9 The support team/care coordinators shall work with the enrollee to assure back-up services for enrollees receiving personal care or other long term care services in the community.

5.10 The support team shall assist with and facilitate enrollees' transitions from institutional settings to the community.

5.11 In the process of coordinating care, CCOs must protect each enrollee's privacy in accordance with federal privacy standards.

5.12 The support team/care coordinator shall provide assistance, as needed, to ensure timely transfers of medical information.

6 Direct Access to Specialists

For enrollees with special health care needs determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring, each CCO must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

7 Self-referral Services

7.1 Enrollees will be permitted to self-refer for reproductive health and family planning services.

7.2 Enrollees will be permitted to self-refer for hospice services.

7.3 Enrollees will be permitted to self-refer to the specialty mental health system as is consistent with MHA policy (for example, enrollees may self-refer for their first twelve outpatient visits).

H. Personal Care and Consumer Direction

1 Introduction

1.1 This chapter describes how enrollees (with their representative if appropriate) will access personal care services and how opportunities for consumer direction will be infused throughout CommunityChoice. This chapter also describes enrollees' rights and responsibilities in obtaining personal care services, and the responsibilities of personal care providers, care coordinators, CCOs, and DHMH in ensuring high quality personal care services. Finally, it describes strategies for monitoring and evaluating enrollee satisfaction and the quality of personal care services.

1.2 Maryland already has established consumer-directed models under its *Living at Home: Maryland Community Choices* Waiver. DHMH plans on building on these models and expanding this option to a broader population, not just home and community-based waiver enrollees. Consumer direction in accessing personal care services will provide older adults and individuals with disabilities with greater independence and autonomy in obtaining services, increase enrollee satisfaction, and improve access to services.

1.3 There are currently approximately 5,400 individuals receiving personal care services in Maryland's Medicaid long term care system (including individuals in the 1915(c) *Living At Home: Maryland Community Choices* and Older Adults Waivers).

1.3.1 There are 390 enrollees in the *Living At Home* Waiver, all of whom receive personal care services. Approximately one-third have chosen to participate in the waiver's consumer-directed care option.

1.3.2 There are 1,400 enrollees in the Older Adults Waiver who receive personal care services in their own homes (most of the remaining individuals in the waiver receive personal care through assisted living providers).

1.3.3 Approximately 3,600 individuals receive personal care services through Maryland's Medical Assistance Personal Care Program.

1.4 Within the CommunityChoice service areas, the personal care benefit will enable all enrollees receiving personal care services to consumer-direct care by participating in care planning and selecting a personal care provider. Individuals needing personal care will choose between two options for obtaining personal care services: the consumer-directed option and a more traditional model of receiving personal care services. DHMH will require participating CCOs to offer both options for enrollees needing personal care services.

1.4.1 Consumer-direction option: All enrollees receiving personal care will participate in care planning and in the selection of a personal care provider. In addition, enrollees selecting the consumer-directed option may direct all or any of the following: (1) hire their personal care providers, (2) train their personal care providers, (3) supervise their personal care providers; (4) negotiate payment rates with their personal care providers; (5) and establish an individualized budget to

meet their personal care needs. This option represents an extension of the current consumer direction option in the *Living at Home* waiver by adding two new features: individualized budgets and flexibility to negotiate payment rates.

1.4.2 Traditional option: All enrollees receiving personal care will participate in care planning and may participate in selecting a personal care provider. In the traditional option, the enrollee may select the personal care provider of their choice within a CCO's network of providers. If an agency is selected, the agency will be responsible for training, supervision, and payment of the personal care provider and for providing back-up services.

2 Care Coordination

2.1 All individuals needing personal care services will have a care coordinator. Enrollees that need personal care services and already meet nursing facility level of care will have already been assigned a care coordinator with a support team.

2.1.1 The care coordinator will provide information about options for obtaining personal care.

2.1.2 The care coordinator will assist the individual to develop a care plan which includes personal care services and to select a personal care provider.

2.1.3 The care coordinator will regularly monitor the delivery of personal care services to ensure enrollees' needs are being met and services are delivered in a manner consistent with the care plan.

3 Development of Care Plan

3.1 All individuals needing personal care services will work with their support team or care coordinator to develop the care plan which includes, but may not be limited to, personal care services. Development of the care plan will include the following components to ensure enrollees' personal care needs are met:

3.1.1 The support team and care coordinator will foster a person-centered approach and respect maximum enrollee/family self-determination while promoting dignity, independence, individuality, privacy and choice. The support team and care coordinator will educate the enrollee on his/her options for obtaining personal care services. The enrollee will use a self-screening process to determine which model of personal care services would be most appropriate to meet his or her needs.

3.1.2 The enrollee will select either the consumer-directed option or the more traditional model for receiving personal care services.

3.1.3 If requested, the support team or care coordinator will assist the enrollee in selecting a personal care provider (see Section 4 below).

3.1.4 The care plan will include a back-up plan for personal care in the event the enrollee's personal care provider is unavailable.

3.1.5 The support team or care coordinator will work with the individual to determine the types of personal care services needed, and the hours/frequency of those services and anticipated future need.

3.1.6 Enrollees in the consumer-directed option will work with their support team or care coordinator to determine their individualized budget based on the type and amount of personal care services needed as identified in the care plan.

3.1.6.1 Enrollees in the consumer-directed option will have the flexibility to negotiate payment rates with their providers. If the enrollee negotiates lower rates, for example, the enrollee could use the remaining funds to pay for other services as needed that are not covered by Medicaid (e.g., adaptive equipment).

3.1.6.2 The CCO has a right to question an individualized budget if they believe the plan of care will negatively impact the enrollee's health. All disputes will be forwarded to DHMH. If DHMH determines that the plan will negatively impact the enrollee's health, the enrollee will be notified of the dispute and will be asked to submit a revised care plan and budget. Based on experiences in other states, this step will be a rare event. CCOs must continue providing personal care services while the dispute is being resolved by DHMH.

3.1.6.3 The CCO will be responsible for paying personal care providers according to rates established in the individualized budget.

3.1.6.4 If the enrollee chooses the consumer-directed option, then the enrollee will work with the CCO to obtain fiscal intermediary services (taxes, payroll, etc.) for purposes of paying the provider.

3.1.7 Care plans and individualized budgets for personal care will be finalized within 30 days of the CCO receiving notification that an individual needs personal care services.

4 Selecting a Personal Care Provider

4.1 Enrollees who choose the consumer-directed option will be allowed to hire personal care providers who are in the CCO's network or independent providers chosen by the individual. Independent personal care providers may include family members (anyone other than a spouse).

4.2 Enrollees in the traditional option may choose among personal care providers in the CCO's network. They may select an independent provider, including a family member other than a spouse. Independent providers must also meet the CCO's standards and enroll in the CCO's network before providing services.

4.3 Personal care providers in a CCO's network will be required to meet certain minimum criteria (e.g., age, criminal history) as they currently do in the Medicaid State Plan and home and community-based services waiver programs. If an independent provider meets all of a CCO's criteria for personal care workers, the CCO must accept the provider into its network if an enrollee requests their services.

4.4 If an enrollee in the consumer-directed option chooses an independent provider outside the CCO's network, the CCOs may advise, but not require, the same criteria for the independent provider outside the CCO's network as for a provider in the CCO's network. CCOs will offer to arrange for criminal background checks, etc., but enrollees may choose to waive these steps. CCOs may also offer training services.

4.5 The support teams or care coordinators will review the care plan with all providers prior to them providing services to ensure that the personal care providers understand their responsibilities and are capable of performing their duties.

5 Enrollee Rights

5.1 Enrollees will have the right to make informed choices about their personal care. DHMH and the CCOs will ensure that enrollees are given accurate and sufficient information in order to make informed choices.

5.2 Enrollees in the consumer-directed option have the right to hire, supervise and fire their personal care providers.

5.3 Enrollees will have the option of choosing their personal care provider.

5.4 Enrollees have the right to regular consultations with their care coordinator and assistance with adhering to the care plan.

5.5 Enrollee have the right to have a representative participate in the care planning process.

5.6 Enrollees have the right to work with their care coordinator to modify their care plan at any time to better suit their health needs.

5.7 Enrollees have the right to request a change of care coordinators or to ask for assistance from an Ombudsman.

5.8 Enrollees in the consumer-directed option have the right to negotiate a lower pay rate with their personal care provider in exchange for other benefits not otherwise covered. Enrollees can also negotiate a higher pay rate (within overall budget constraints) with the provider of their choice.

5.9 Enrollees have the right to discontinue the consumer-directed option of receiving personal care and change to the traditional method of receiving personal care at any time. Likewise, enrollees receiving personal care through the traditional model may request to change to the consumer-directed option at any time. In these cases, the care coordinator will work with the enrollee to revise the personal care plan as appropriate.

6 Responsibilities

6.1 This section addresses the responsibilities of the participating entities.

6.2 Five entities will participate in the personal care benefit: the enrollee, the personal care worker, the support team or care coordinator, the CCO, and DHMH and its State partner.

6.3 Responsibilities of the participating enrollee or their delegated representative:
Enrollees are responsible for adhering to the care plan agreed upon with their care coordinator, and report any deviations from the care plan to their care coordinator.

Enrollees are responsible, to the best of their abilities, for maintaining the workplace for the personal care worker.

6.4 Responsibilities of the participating personal care worker:
Workers are expected to be proficient in care giving duties to the satisfaction of the enrollee.

Workers are expected to report cases of enrollee abuse or neglect that come to their attention.

6.5 Responsibilities of the participating care coordinator:
The support team or care coordinator will be responsible for assisting the enrollee in designating an authorized representative (if appropriate) and developing the care plan, individualized budget and the back-up plan; providing consultation with regard to hiring, training and supervising workers; and monitoring program quality and initiating action to correct problems.

The support team or care coordinator will schedule regular consultations with the enrollee and personal care worker to monitor the health status of the enrollee and other quality of life indicators and report back to the CCO any potential issues/concerns.

6.6 The responsibilities of the CCO are as follows:
CCOs will be responsible for providing an adequate network of personal care providers and care coordinators.

CCOs will be responsible for monitoring quality and must have the ability to report performance data back to DHMH for quality monitoring.

CCOs will be responsible for making care plans available for review by DHMH, if necessary.

CCOs will be responsible for providing informational materials to enrollees and personal care providers to educate them on the two options for personal care.

CCOs must establish credentialing criteria for all personal care workers in their network.

CCOs' personal care provider credentialing criteria must at a minimum meet DHMH requirements.

6.7 The responsibilities of DHMH and its State partners are as follows:

DHMH is responsible for the overall monitoring and regulation of the program.

DHMH, in partnership with MDoD and MDoA, will be required to establish a strategy for evaluating the quality and overall success of the program.

7 Quality Assurance

7.1 Program evaluation will be essential in order to assess whether enrollees are accessing high quality personal care services. A baseline and ongoing evaluation will be conducted by DHMH to determine the effectiveness of personal care in meeting enrollees' needs.

7.2 Over the first year of this waiver, DHMH, MDoD, and MDoA will examine how the State can increase consumer control over a broader array of services, how it can transition to a cash and counseling program, and DHMH, MDoD, and MDoA can enhance consumer direction.

7.3 DHMH intends to measure CCO performance through a set of key performance measures. These measures may include:

- Implementing a care plan (within 30 days);
- Timeliness of handling complaints and grievances;
- Individualized budget denial rates;
- Personal care provider network adequacy.

7.4 DHMH and its State partners will also monitor enrollee/provider satisfaction in both models of receiving personal care. Key satisfaction measures that may be compared/contrasted in both models:

- Enrollee satisfaction;
- Provider satisfaction;
- Responsiveness to grievances;
- Negotiated payment rates in the consumer-directed option – provider/enrollee satisfaction;
- Timeliness of provider payment;
- Other quality of life indicators.

I. Access Standards

1 Introduction

1.1 This chapter describes the access standards that the Department will use to ensure that every CCO can appropriately and efficiently provide the benefits covered under the waiver. Service and clinical quality access standards are outlined, in addition to methods for communicating these standards to enrollees and providers.

2 Education and outreach

2.1 DHMH and CCOs will inform CommunityChoice enrollees of covered benefits and how to access services, particularly primary and specialty care, home and community-based services, nursing facility, mental health, pharmacy, and emergency services. DHMH and CCOs will educate enrollees on their right to fill out a Patient Advocate Designation Form. An explanation for the purpose and process for filling out the form will be provided.

DHMH will ensure that information systems are in place to facilitate information sharing between eligibility workers, the enrollment broker, and the CCO/care coordinator. Enrollee outreach and education will be provided at every step to ensure enrollees understand the process.

DHMH and its State partners will monitor outreach and education activities to ensure enrollees receive information in a culturally sensitive manner that facilitates an understanding of CommunityChoice benefits and how to access care. Written materials will be available at appropriate reading comprehension levels, and in the enrollee's native language where a single group constitutes at least 3 percent of the population. Information will be provided in a manner that accommodates individuals with disabilities consistent with the requirements of the Americans with Disabilities Act of 1990.

2.2 CCOs will issue a manual to all participating providers to provide information and updates on the program, policies and procedures, and clinical access standards. CCOs' provider manuals will include information on the expectation that providers educate patients on their right to designate an individual (e.g., a family member) to have access to their private medical information. CCOs will also emphasize the importance of timely transfers of medical information between providers.

The CCOs will ensure that providers receive necessary training on the Medicaid program within four weeks after the provider is contracted, and on an ongoing basis thereafter as needed. CCOs will provide regular updates to providers to inform them of any program or policy changes, and will provide primary care providers with regular updates on their assigned Medicaid enrollees.

3 Provider network and capacity standards

3.1 CCOs that participate in CommunityChoice will be required to develop, monitor, and maintain an adequate network of primary care, specialist, pharmacy, nursing facility, personal care, and home and community-based long term care providers to meet the

individual needs of enrollees and provide adequate and timely access to the full scope of benefits covered under the waiver. CCOs may not participate in CommunityChoice until an adequate provider network is in place.

3.2 Access standards outlined in this chapter apply to services where Medicaid is the primary payer. For example, primary care provider and pharmacy standards do not apply for the dual eligible CommunityChoice population because they will receive their primary care and pharmacy services through Medicare. However, Medicaid will be the primary payer for long term care services for all recipients covered under CommunityChoice.

3.3 CCOs' provider networks will comply with the geographic and clinical standards outlined in the sections below and will cover services for all levels of primary, acute/inpatient, outpatient, emergency, tertiary, post-acute, and long term care.

3.4 CCOs will promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds. CCOs may be asked to present the cultural and ethnic profile of the providers in their networks in order to demonstrate how their provider networks accommodate the cultural and ethnic diversity of the enrollees they serve.

3.5 In establishing and maintaining provider networks, each CCO must consider the following:

3.5.1 The plan's anticipated enrollment;

3.5.2 The expected utilization of services, taking into consideration the characteristics and health care needs of the specific populations enrolled in the CCO;

3.5.3 The number and types (in terms of training, experience, and specialization) of providers necessary to furnish CommunityChoice services;

3.5.4 The number of network providers who are and are not accepting new Medicaid patients;

3.5.5 The geographic location of providers and CommunityChoice enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for CommunityChoice enrollees with disabilities.

3.6 The CCO will maintain and regularly update a listing of available providers, their locations, and whether the practice site is open or closed. The CCO will provide the Department the listing no less frequently than the following:

3.6.1 During the CCO qualification review;

3.6.2 At the time the CCO enters into contract with the State;

3.6.3 At any time there has been a significant change in the CCO's operations that would affect adequate capacity and services, including changes in the CCO's

services, benefits, geographic service area or payments; or enrollment of a new population in the CCO; and

3.6.4 Anytime the Department requests it.

3.7 The Department will perform an initial evaluation prior to the implementation of CommunityChoice and periodic re-evaluation thereafter of the CCO's provider networks to ensure networks are adequate. The Department will validate CCO's reported provider networks by surveying a sample of providers to verify their participation in the CCO's network. The Department will certify to CMS that the CCO has complied with State requirements for availability of services, and will make available, upon request, all provider network adequacy documentation collected by the State from the CCO.

3.8 The Department will require corrective action and may impose sanctions if a CCO fails to comply with established provider network adequacy standards.

4 Primary care provider access standards

4.1 Each CommunityChoice enrollee for whom Medicaid is the primary payer will have a primary care provider (PCP) to serve as the enrollee's medical home. The PCP will serve as the primary coordinator of medical care. Dual eligible enrollees will receive their primary and preventive care services through the Medicare program. The enrollee may change his/her PCP at any time. The enrollee's PCP assignment will be based upon the following:

4.1.1 The enrollee's selection of a PCP from the CCO's panel of qualified providers; or

4.1.2 The CCO's assignment of PCP from its panel of qualified providers if the enrollee does not select a PCP.

4.2 The CCO will be required to meet a primary care capacity standard of one full-time equivalent primary care provider (PCP) for every 200 enrollees (for whom Medicaid is the primary payer) in the service area. Exceptions will be made if the CCO can document that its providers can serve more Medicaid recipients.

4.3 Medical health care services provided by the PCP may include but are not limited to the following:

4.3.1 Preventive health services;

4.3.2 Primary acute care;

4.3.3 Chronic medical care;

4.3.4 Arrangement for consultation, referral, and follow-up with specialists;

4.3.5 Referral for specialty mental health services and ancillary/support health services, including drug therapies, medical supplies, and durable medical equipment;

4.3.6 24 hour/day, 7 days per week provider coverage for emergency medical services;

4.3.7 Maintenance of a medical record.

4.4 The CCO provider network may include any of the following to serve as the PCP:

4.4.1 General practitioner;

4.4.2 Family practitioner;

4.4.3 Internist;

4.4.4 Geriatrician;

4.4.5 Advanced nurse practitioner;

4.4.6 Specialists, if appropriate.

5 Care coordinator access standards

5.1 CommunityChoice enrollees who meet nursing facility or chronic hospital level of care will be assigned to a support team. Enrollees who receive personal care services will be assigned a care coordinator by the CCO. CCOs may also choose to offer care coordination to other populations.

5.1.1 Care coordinators will be responsible for developing and monitoring care plans to ensure that enrollees' needs are met. Standards for the development, review, and renewal of care plans are described in the Chapter J, Quality.

5.1.2 Care coordinators may be a part of the CCO's staff or subcontracted by the CCO.

5.1.3 Enrollees may change their care coordinators at any time.

5.2 For enrollees meeting nursing facility level of care or needing personal care services, the Department proposes that CCOs will ensure a care coordinator to enrollee ratio of 1:50 for individuals served in the community. For enrollees in nursing facilities or chronic hospitals, the Department proposes that CCOs will ensure a care coordinator to enrollee ratio of 1:120. The CommunityChoice Advisory Group will assist the Department in evaluating and finalizing care coordinator to enrollee ratios.

The Department will monitor CCOs' care coordinator to enrollee ratios to ensure care coordinator caseloads are appropriate.

6 Specialty provider access standards

6.1 The Department will develop specialty provider network standards by service area based on enrollment, enrollees' characteristics and service needs, and the locations of specialty

provider offices. The Department will require every CCO to have a core network of specialty providers which will include at a minimum:

6.1.1 Cardiology;

6.1.2 Otolaryngology (ENT);

6.1.3 Gastroenterology;

6.1.4 Gerontology;

6.1.5 Neurology;

6.1.6 Oncology;

6.1.7 Ophthalmology;

6.1.8 Orthopedics;

6.1.9 Pulmonologist;

6.1.10 Nephrologist;

6.1.11 Rheumatologist;

6.1.12 Gynecology;

6.1.13 Surgery; and

6.1.14 Urology.

6.2 Regional specialty network standards will be established based on the locations of specialty provider offices and the population served by the CCOs.

6.3 The Department will regularly review CCOs specialty provider networks to ensure CCOs' networks are adequate.

6.4 CCOs will be encouraged to allow specialists to serve as PCPs when appropriate.

6.5 The CCO will provide female enrollees (for whom Medicaid is the primary payer) with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's PCP if the PCP is not a women's health specialist.

6.6 If requested by enrollees for whom Medicaid is the primary payer, the CCO will provide for a second opinion from a qualified health care professional within the network, or arrange for the enrollee to obtain one outside the network, at no cost to the enrollee.

7 Home and community-based services access standards

7.1 The Department, with the assistance of the CommunityChoice Advisory Group, will establish home and community-based long term care provider network standards to ensure adequate access to home and community-based providers, including licensed medical day care, personal care, home health, and licensed assisted living providers. The Department will regularly review CCOs' home and community-based provider networks to ensure CCOs' networks are adequate.

7.2 At initial implementation of the CommunityChoice program, assisted living residents and regular participants at medical day care centers will be permitted to stay with their existing facility or center, unless documented quality of care problems exist.

8 Nursing facility access standards

8.1 The Department will require CCOs to reimburse any licensed nursing facility that participates in Medicaid.

8.2 An individual who meets nursing facility level of care standards will always be permitted to remain in a nursing facility or transition into a nursing facility. Individuals who only require short-term rehabilitation care in a nursing facility, however, will need to transition back to the community when they no longer meet the nursing facility level of care standard.

9 Out-of-network access and referral standards

9.1 If the CCO's network is unable to provide necessary covered services to a particular enrollee, the CCO must arrange for these services out of network for the enrollee.

9.2 CCOs will coordinate with out-of-network providers with respect to payment and ensure that cost to the enrollee is no greater than it would be if the services were provided within the CCO's network.

9.3 CCOs will be financially responsible for medically necessary covered services delivered outside the CCOs' service area.

9.4 CCOs may require authorization for treatment for services delivered to enrollees outside the CCOs' service area, with the exception of emergencies.

9.5 CCOs will clearly specify referral requirements to PCP, specialist, and long term care providers. CCOs will require providers to maintain records of referral arrangements and the outcomes of those referrals within the enrollees' medical records.

10 Geographic access

10.1 CCOs will ensure that all enrollees have reasonable travel times to receive Medicaid-covered services.

10.2 Enrollees in urban areas must be able to access covered primary care services and medical day care within 30 minutes travel time or within a 10 mile radius of the provider office, and covered pharmacy services within 10 minutes travel time or within a 5 mile radius.

10.3 Enrollees in rural areas must be able to access covered primary care and pharmacy services within 30 minutes travel time or within a 30-mile radius of the provider office.

10.4 Enrollees in rural areas must be able to access medical day care within 45 minutes travel time or within a 30-mile radius.

10.5 The Department will establish urban and rural local access areas to monitor adequate geographic access to providers by service area.

10.6 The Department will monitor CCOs' compliance with geographic access standards and may require corrective action or impose penalties if a CCO fails to comply with the established standards.

11 Clinical access

11.1 CCOs will define specific guidelines that address how requests for appointments will be arranged. The interval between the request for appointment and the actual appointment will adhere to the following parameters:

11.1.1 CCOs will ensure that new enrollees who need special or immediate health care services, as identified by a health risk assessment, receive them in a timely manner. CCOs will make telephone contact with all new enrollees (or their family members/representative) within seven days of their enrollment to coordinate any appointments that are needed.

11.1.2 CCOs will ensure that new enrollees (for whom Medicaid is the primary payer) who are identified as high risk are scheduled to have an initial appointment with their PCPs within 15 days of the CCO's receipt of the health risk assessment unless the enrollee is assigned to a PCP who was the enrollee's established provider of care immediately before enrollment, and the PCP concludes that no immediate initial appointment is necessary.

11.1.3 CCOs will ensure that new enrollees (for whom Medicaid is the primary payer) are scheduled to have initial appointments with their PCPs within 90 days of enrollment in the CCO unless a shorter time frame applies (as in 12.1.2), or the enrollee is assigned to a PCP who was the enrollee's established provider of care immediately before CommunityChoice enrollment, and the PCP concludes that no immediate initial appointment is necessary.

11.2 CCOs will notify each enrollee for whom Medicaid is the primary payer of their due date for an examination, immunization, or other wellness service in a timely manner.

11.3 CCOs will ensure that covered benefits are available to enrollees 24 hours a day, 7 days a week when medically necessary.

11.4 When needed, CCOs will pay for and assist enrollees in securing transportation to and from appointments.

11.5 The Department will require CCOs' care coordinators or designated member of the support team to make initial phone contact within 7 days and conduct a comprehensive face-to-face assessment and develop and initiate the care plan within 30 days from the date of the nursing facility level of care determination, or notification of an enrollee's need for personal care services.

11.6 Enrollees requesting routine and preventive primary care appointments will be seen within 60 days of the request.

11.7 Enrollees requesting urgent care will be scheduled to be seen within 48 hours of the request.

11.8 Enrollees requesting routine specialist follow-up appointments will be seen within 60 days of the initial authorization from the enrollee's PCP, or sooner as deemed necessary by the PCP. The PCP will be responsible for making the appointment directly with the specialist's office.

11.9 CCOs will respond in a timely manner to enrollees' needs and requests as follows:

11.9.1 If the enrollee arrives early or on time for a scheduled appointment, waiting time to be seen for a regular office visit may not exceed 1 hour after the scheduled appointment time;

11.9.2 If the enrollee is experiencing a medical emergency, the enrollee should go directly to the emergency facility. If the enrollee questions whether or not their health condition meets the prudent layperson standard of an emergency, the enrollee may contact the CCO for guidance on whether to seek emergency facility care. CCO representatives will respond to patients' inquiries as to whether or not to use emergency facilities within 30 minutes;

11.9.3 For non-emergency services requiring preauthorization by the CCO, the CCO will provide preauthorization in a timely manner so as not to adversely affect the health of the enrollee, but not later than 72 hours after the initial request;

11.9.4 The CCO will notify the provider in writing whenever the provider's request for preauthorization is denied.

11.10 CCOs will establish, and will require their contractors to establish, a reasonable schedule of operating hours, consistent with enrollees' utilization patterns and providers' hours of operation for the community at large. At a minimum, service delivery sites will be open to enrollees as follows:

11.10.1 For providers who are individual practitioners, operating hours will be at least 20 hours per week and at least three days per week;

11.10.2 For group practices or facilities, the operating hours will be at least 35 hours per week; and

11.10.3 CCOs will establish reasonable hours of access to pharmacy services for enrollees (for whom Medicaid is the primary payer) which will include weekend and evening hours equivalent to the hours pharmacy services are generally available in the service area to the public at large.

11.11 The Department will monitor CCOs' compliance with clinical access standards and may require corrective action or impose penalties if a CCO fails to comply with the established standards.

12 Emergency services access

12.1 The CCO will maintain policies and procedures for the provision of emergency service where Medicaid is the primary payer.

12.2 The CCO will provide medically necessary emergency services to enrollees (for whom Medicaid is the primary payer) 24 hours per day, seven days per week. The delivery of these services may be accomplished through access to an appropriate health care provider, by a health care professional consultation (e.g., nurse triage phone service), or through the CCOs' contracted emergency facilities. CCOs will use medical professionals who will perform adequate and appropriate triage assessments. CCOs will make arrangements with hospital emergency providers or urgent care centers to ensure prompt, high quality treatment.

12.3 CCOs will be responsible for reimbursing hospital emergency facilities and providers for enrollees (for whom Medicaid is the primary payer) for the following:

12.3.1 Health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine, to result in:

12.3.1.1 Placing the patient's health in serious jeopardy;

12.3.1.2 Serious impairment to bodily functions; or

12.3.1.3 Serious dysfunction of any bodily organ or part.

12.3.2 Medical screening services based upon the federal Emergency Medical Treatment and Active Labor Act (EMTALA);

12.3.3 If the CCO authorized, referred, or otherwise allowed the enrollee to use the emergency facility, medically necessary services that are related to the condition for which the enrollee was allowed to use the emergency facility;

12.3.4 Medically necessary services relating to the condition presented and treated in an emergency facility if the CCO fails to provide 24-hour access to a physician.

12.4 The CCO may require that any continuing care be obtained from the CCO's providers or from providers approved by the CCO when the following conditions are satisfied:

12.4.1 The enrollee's medical condition is appropriately stabilized and permits transferring responsibility for the enrollee's care to the CCO's providers without medically harmful consequences; and

12.4.2 The transfer is consistent with the requirements of the federal Emergency Medical Treatment and Active Labor Act (EMTALA).

12.5 The CCO will be responsible for the payment and coordination of services provided by out-of-plan providers when emergency care is given to enrollees either inside or outside the service area based upon the following conditions:

12.5.1 The emergency service is needed immediately for an emergency medical condition; or

12.5.2 The enrollee is not able to receive the emergency care at the CCO's designated site because the time required to reach the facility would mean risk or serious impairment of bodily function.

12.6 The CCO may choose to set notification and claim filing parameters in the event of out-of-plan emergency care, however, failure to give notice or file claims within the established time frames may not be used to deny claims if it can be shown that notice was given as soon as was reasonably possible, given the nature of the illness and injury.

J. Quality

1. Introduction

1.1 This chapter outlines the various methods DHMH will use to ensure the delivery of high quality health care by all CCOs to CommunityChoice enrollees. The quality of health care is the degree to which delivered health services maximize positive health outcomes and minimize negative outcomes. High quality health care promotes the best possible quality of life for enrollees, assures the rights and safety of enrollees, preserves enrollees' individual preferences and self-determination, and meets established professional standards. The quality strategy will assure that enrollees have access to care and consumer protections.

1.2 The goal of the comprehensive CommunityChoice quality strategy is to promote the health and well-being of enrollees by (1) assuring enrollee access to services; (2) holding CCOs accountable for outcomes; and (3) promoting cost-effective delivery of services. In addition to proactively promoting high quality care, the strategy will quickly identify and correct any systemic problems that arise. The quality strategy will balance DHMH's and CCOs' responsibility to provide extra protections for services delivered in an individual's home with the desire for individuals to be independent and to freely control their service delivery. To ensure safety in the community, processes will be in place to detect and immediately address issues of neglect and mistreatment. The CommunityChoice quality strategy will comply with federal and Maryland requirements for managed care.

1.3 Details of the quality strategy outlined in this chapter will be developed with public input via the CommunityChoice Advisory Group and the regulatory process. Examples of details to be determined with public input include specific CCO performance measures and target levels for performance. Consumer input will help identify measures that are meaningful to enrollees.

1.4 DHMH will share CommunityChoice quality results with the public and enrollees so enrollees can make informed decisions about their care.

1.5 While DHMH's Office of Health Care Quality (OHCQ) will continue to be responsible for provider-level licensing and inspections, CommunityChoice will introduce quality assurance and quality improvement initiatives for long term care services. CommunityChoice represents a newly increased level of quality oversight for the target population. Under the traditional fee-for-service long term care system there were few quality initiatives beyond licensure and response to specific complaints. Under CommunityChoice, the Medicaid administration within DHMH will monitor CCOs and hold them accountable for the quality of care delivered to their enrollees. DHMH will lose none of the quality tools held under the long term care system (such as oversight of appeals and monitoring of care coordination), and will add a new level of accountability and oversight to the system.

1.6 DHMH has a comprehensive approach for evaluating managed care organization (MCO) performance in HealthChoice, Maryland's statewide mandatory managed care program which serves most non-elderly, non-institutionalized Medicaid beneficiaries. The

CommunityChoice quality strategy will build on some components of the HealthChoice quality strategy. However, CommunityChoice quality will be tailored to the different needs of older adults and people with disabilities, services provided in the home, and services provided under a consumer-directed model. Assessment of enrollee experiences and satisfaction with the delivery system will be essential. Quality activities specific to consumer direction will be integrated into the overall CommunityChoice quality strategy and are discussed in Chapter H, Personal Care and Consumer Direction.

2 Overview of Quality Strategy

2.1 Only qualified CCOs will be approved by DHMH for participation in CommunityChoice. DHMH will review applicant CCOs to ensure that only those organizations that can provide high quality care, have adequate provider networks, are financially stable, and have the necessary administrative and operational infrastructure will participate.

2.2 Oversight of the quality of health care delivered to enrollees will exist at two levels: at DHMH and at individual CCOs. DHMH will have a written strategy for assessing and improving the quality and appropriateness of care delivered by all CCOs to their enrollees. DHMH will continuously assess and evolve its quality strategy to ensure that it is effective. DHMH will involve enrollees and other stakeholders in the development of the quality strategy, and will share and report on its quality strategy with CMS. The quality strategy will meet all State and federal requirements.

2.3 DHMH will require corrective action and may impose sanctions if a CCO's performance is below established standards. Sanctions are discussed further in the Chapter C, Delivery System (Section 9). DHMH will work with the CommunityChoice Advisory Group to develop more detailed criteria and methodology for applying sanctions.

2.4 DHMH will define specific measures of quality and access to services. DHMH will also define standards for CCO performance on these measures. DHMH will identify measures that are meaningful to older adults and individuals with disabilities.

2.5 The different parts of the comprehensive CommunityChoice quality strategy include:

- Systems performance review;
- Outcome measures established by DHMH, including clinical outcomes incorporated in a quality of care audit;
- Care coordination;
- Enrollee satisfaction;
- Provider satisfaction;
- CCO performance improvement projects;
- Focused studies using chart reviews to help assess CCO performance in areas that cannot be evaluated using encounter data; and
- Each CCO will also be required to have a consumer advisory board to receive regular input from enrollees.

2.6 CCO performance on the requirements included throughout this waiver will be part of the quality strategy, including but not limited to:

- Enrollment and disenrollment;
- Enrollee information;
- Provider access and timeliness of care;
- Coverage and authorization of services; and
- Care coordination and continuity of care.

The quality strategy may also include measures mandated by CMS.

2.7 Annually, an independent external quality review organization (EQRO) contracted by DHMH will conduct an external quality review (EQR) to assess CCO performance on State-collected measures of health care quality and timely access to services. These EQRO activities will be consistent with BBA. The EQRO will be a federally approved quality improvement organization (QIO). The annual EQRs will ensure that assessments of quality are fair and objective and reported results are accurate, enabling comparisons among CCOs to be made.

2.8 DHMH will conduct monitoring activities which need to occur more than once per year outside of the formal EQR. For example, DHMH will monitor the adequacy of CCO provider networks and complaint systems in accordance with the standards established in Chapter I, Access Standards and Chapter K, Complaints and Appeals. Ongoing monitoring outside of the annual EQR will allow DHMH to be responsive to immediate needs of the enrollee population and work with CCOs to remedy any deficiencies.

2.9 In addition, each CCO will have a DHMH-approved ongoing quality assurance and quality improvement program for the services it delivers to its enrollees. In addition to promoting quality among DHMH-required measures, CCOs may implement their own performance improvement projects for clinical or non-clinical areas. Performance improvement projects are designed to achieve significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. These projects involve measurement of performance using objective quality indicators; implementation of system interventions to achieve improvement in quality; evaluation of the effectiveness of the interventions; and planning and initiation of activities for increasing or sustaining improvement.

2.10 In addition to quality oversight, DHMH will conduct financial oversight of CCOs. As discussed in Chapter M, Evaluation and Reporting, CCOs will be required to regularly submit financial monitoring reports and annually submit financial filings with the Maryland Insurance Administration. DHMH will conduct CCO financial audits on a regular basis and will compile a publicly available report summarizing the audit findings. As discussed in Chapter L, Financing (Section 2.1), DHMH with the Advisory Group will develop regulations that address the level of CCO capitation rates that must be spent on medical expenses to ensure that CCO payments are used for enrollee services.

3 Systems Performance Review

3.1 The EQRO will perform an annual, on-site systems performance review of each CCO to ensure that CCOs have the infrastructure necessary to deliver high quality care to their enrollees. After CCOs show high performance on specific measures, DHMH may exclude those measures from future annual reviews within a three-year period. CCO systems reviews will be similar to HealthChoice system reviews, with some new areas such as home and community-based service provider credentialing and access standards. The systems performance review will assess the components outlined in the chart below. Several of the components (written annual QA plan, credentialing and recredentialing, utilization management) are further described below.

Systems Performance Review	
Component	**Description of What's Reviewed**
Written Annual Quality Assurance (QA) Plan	CCOs have written plans for their internal quality assurance and performance improvement programs. Described further below.
Systematic Process of QA/ Improvement	CCOs have processes to monitor quality, including clinical care standards and practice guidelines. Appropriate clinicians monitor and evaluate quality for individual case reviews. There is evidence of development, implementation, and monitoring of corrective actions.
Accountability to the Governing Body	The governing body provides oversight of the CCO, approves the QA Program and annual QA Plan, designates accountable entities when oversight not directly performed by the governing body, and receives routine reports on quality.
Active QA Committee	The QA Program defines an identifiable structure responsible for performing QA functions within the CCO.
QA Plan Supervision	There is a designated senior executive responsible for program implementation. The CCO's medical directors have substantial involvement in QA activities.
Adequate Resources	The QA Program has material resources and staff with the necessary education, experience, or training to effectively carry out its specified activities.
Provider Participation	Participating physicians and other providers are kept informed about and participate in the written QA Plan.
Delegation of QA Plan	The CCO remains accountable for all functions, even if certain functions are delegated to other entities.
Credentialing and Recredentialing	QA Programs contain all required provisions to determine whether physicians and other health care professionals who are licensed by the State and under contract with the CCOs are qualified to perform their services. Described further below.
Enrollee Rights	CCOs have processes demonstrating commitment to treating members in a way that acknowledges their right and responsibilities. See Chapter F, Enrollee Rights and Responsibilities and Chapter K, Complaints and Appeals.
Availability and Access	CCOs have standards for ensuring access to care as well as fully implemented systems to monitor performance against standards.
Medical Records	Medical records are available for DHMH quality reviews. Medical records are available to appropriate health care providers at each encounter. CCOs have standards for medical record content.

Systems Performance Review	
Component	**Description of What's Reviewed**
Utilization Management	CCOs have utilization management plans, which describe procedures to review and approve the provision of medical services. Utilization management plans will include criteria used and information sources, and will assure that qualified medical personnel supervise decisions. Described further below.
Continuity of Care	CCOs have systems in place that promote continuity of care and care coordination. Findings, conclusions, actions taken, and results of actions taken as a result of QA activities are documented and reported to appropriate individuals within the CCO and through established QA channels. Resources (such as automated tracking systems) are allocated to facilitate communications among members, PCPs, other health care professionals, and care coordinators.
QA Program Documentation	CCOs monitor quality of care across all services and treatment modalities according to QA Programs.
Coordination of QA Activities with Other Management Functions	CCOs document and report to the appropriate individuals and committees on findings, conclusions, actions taken, and results of actions taken. CCOs use quality information in recredentialing, recontracting and/or performance evaluations. CCO quality activities are coordinated with other performance monitoring activities.
Health Education Plan Review	CCOs have health education plans to educate enrollees about programs and health care services.
Outreach Plan Review	CCOs have comprehensive written outreach services plans to assist enrollees in overcoming barriers in accessing health services. The Outreach Plan (OP) adequately describes the populations to be served, activities to be conducted throughout the year, and identifies monitoring activities. There must be evidence that the CCO has implemented the OP, appropriately identified the populations, monitored outreach activities, and made modifications if appropriate.
Claims Payment Review	CCOs have processes for the timely payment of claims (within 30 days) and payment of interest on claims not paid within 30 days. Claims systems must address claim acceptance and payment consistent with the requirements of the Maryland Insurance Administration.
Encounter Data and Health Information System	CCOs maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of the quality strategy. Systems provide information on utilization, complaints and appeals, and disenrollments for reasons other than loss of Medicaid eligibility. See Chapter L, Financing.

3.2 Written Annual Quality Assurance (QA) Plan. The systems performance review will assess each CCO's QA Plan. Each CCO's QA Plan will include:

3.2.1 Status and results of performance improvement projects. Each performance improvement project must be completed in a reasonable time period. Examples of possible performance improvement projects are: dementia care; and delivery of DMS/DME.

3.2.2 Submission of performance measurement data for the EQR and submission of other performance data specified by DHMH.

3.2.3 Mechanisms to detect both over- and under-utilization of services.

3.3 Credentialing and Recredentialing. The systems performance review will assess whether each CCO has processes to credential and recredential providers to determine that they are qualified to perform their services.

3.3.1 The State will establish a uniform policy that each CCO must follow for credentialing and recredentialing of providers who have signed contracts with the CCO. CCOs will be required to comply with State licensure regulations for providers (for example, medical day care providers, assisted living facilities, and nursing facilities must all be licensed) and will be required to meet all additional standards established by DHMH (for example, use of the Uniform Credentialing Form). Each CCO will have written policies and procedures for initial credentialing and recredentialing, and evidence that these policies and procedures are functioning effectively. Chapter H, Personal Care and Consumer Direction discusses credentialing for personal care providers hired through the consumer directed model.

3.3.2 CCOs will determine if providers within their networks are having, or have had, fraud and abuse sanctions made against them. CCOs will conduct credentials verification through query of the "National Practitioner Data Bank," the State Board of Physician Quality Assurance, Health Claims Arbitration Office, and Medicare Intermediaries and Medicaid Agencies for fraud and abuse identification of providers who have been terminated from Medicare or Medicaid participation.

3.3.3 CCOs may not employ or contract with providers excluded from participation in federal health care programs.

3.3.4 CCO provider selection policies and procedures must not discriminate against providers who serve high-risk populations or specialize in conditions that require costly treatment.

3.3.5 CCOs will contract with providers in the community who can provide services that are accessible. CCOs will include provider compliance with the Americans with Disabilities Act (ADA) as part of their provider credentialing processes.

3.3.6 CCO provider contracts and/or employment agreements will include requirements to participate in quality improvement activities.

3.4 Utilization Management. The systems performance review will assess CCOs' utilization management plans, which describe procedures to review and approve the provision of medical services. Utilization management plans will include criteria used and information sources, and will assure that qualified medical personnel supervise decisions.

3.4.1 Each CCO will be required to have a DHMH-approved written utilization management (UM) plan that assures timely access or transfer to appropriate levels of care. This will ensure that access to services is consistent throughout the CommunityChoice service areas. The UM plan includes:

- Referral process;
- Services requiring pre-authorization and timelines for processing authorization requests. This is discussed further in Chapter I, Access Standards;
- Criteria for determining medical necessity. In general, the need for services will be determined in conjunction with the individual, family, care coordinators, and providers. This will include consideration of what individuals need to maintain their functional abilities and independence in the community. Ultimate authority for CCO denial of services lies with CCO Medical Directors. Denials may be appealed to DHMH;
- Provider responsibilities for UM activities;
- Care coordination processes;
- Utilization tracking mechanisms and the determination of over- and under-utilization of services;
- Complaints and appeals processes for providers and enrollees. These are discussed in Chapter K, Complaints and Appeals.

3.4.2 The CCO will have an information system to produce reports for studying over- and under-utilization, quality of care indicators, and data on inpatient hospital admissions, emergency room use, nursing facility use, ancillary service use, home and community based service use, and out-of-area service provision.

3.4.3 Each CCO will adopt practice guidelines. Practice guidelines are used to assist providers in approaching a health care issue in a systematic, appropriate, evidence-based manner. Practice guidelines or protocols actively promote the quality of care, reduce variations in care, and assist providers in making decisions about care for specific patients. CCO practice guidelines will meet the following requirements:

- Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field, such as the U.S. Preventive Services Task Force Guide to Clinical Preventive Services;
- Consider the needs of CCO enrollees;
- Are adopted in consultation with contracting health care professionals;
- Are reviewed and updated periodically as appropriate.

3.4.4 Each CCO will disseminate practice guidelines to affected providers and, upon request, to enrollees and potential enrollees.

3.4.5 Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply will be consistent with the guidelines.

4 Outcome Measurement

4.1 DHMH will define specific, objective measures of quality and access. Measures, and the population of interest for any given measure, will be clearly defined.

4.2 DHMH will define standards for CCO performance on these measures. CCOs will have to achieve minimum performance standards and show improvement over time. Standards may be based on recently available national Medicaid data, or if no national data exist, on the analysis of previous years' Maryland Medicaid data.

4.3 Section M: Evaluation and Reporting discusses the data that will be available from the CCOs to allow DHMH to assess performance. CCOs must provide complete and accurate encounter data in standard formats for every enrollee. Additional data sources are HEDIS, focused studies, medical record review, complaints and appeals to CCOs and DHMH, satisfaction survey results, and focus groups.

4.4 A key part of the annual EQR will be the validation of State-collected performance measures used as part of the quality of care audit.

4.5 DHMH's set of measures may evolve, or measures may be rotated, over time. This will allow the quality strategy to be responsive to changing priorities or areas of interest.

4.6 Health status can be considered one of the ultimate measure of quality of care. The CommunityChoice quality strategy will include monitoring of enrollee health status. Examples of health outcomes that may be included are: change in health status or functional status; rates of preventable hospitalization; or rates of decubitis ulcers.

4.7 Because the delivery of some health services is clearly known to result in good health outcomes, measuring the delivery of the service is a proxy for the positive health outcome. For example, the delivery of comprehensive diabetes care is widely accepted in the medical community to result in better health outcomes for people with diabetes. Other examples are rates of influenza vaccinations or pneumonia vaccinations, which are known to reduce incidence of influenza and pneumonia, respectively. Measurement of service delivery can be simpler and more objective than measurement of health status. Therefore, in addition to measuring actual health outcomes, the CommunityChoice quality strategy will measure the delivery of services known to result in improved health outcomes.

4.8 In addition to measuring health status and delivery of services, DHMH will also assess outcomes that are important but are not actual health status outcomes. Examples are:

- Percent of people meeting nursing facility level of care who are served in the community;
- Percent of people meeting nursing facility level of care who are served in different community-based settings; and
- Percent of people who are transitioned out of nursing facilities into the community.

4.9 DHMH will work with stakeholders to develop the measures.

4.10 DHMH will consider factors such as the following in the selection of measures:

- The range of services covered under CommunityChoice;
- What outcomes are important to CommunityChoice enrollees;
- How outcomes may be prioritized differently by different CommunityChoice populations (e.g., individuals who do or do not meet nursing facility level of care);
- What services are important to individuals enrolled in CommunityChoice;
- What services are important to high risk populations in CommunityChoice;
- What services have the maximum benefit for the overall CommunityChoice population (for example, because prevalence of a given condition requiring that service is high);
- How or whether measurement should differ for individuals who select the consumer-directed model (quality of the consumer direction model are discussed further in Chapter H, Personal Care and Consumer Direction);
- What additional data will be needed to calculate measures;
- Whether measures are evidence-based (i.e., delivery of a given service is known to improve health outcomes);
- Whether results can be compared to analyses in other states or in the commercial market;
- Whether CCOs can be held accountable for a given health outcome.

4.11 DHMH will assess the measures currently collected in Maryland and nationally. Existing tools to assess quality in long term care, such as the Minimum Data Set (MDS) which assesses nursing facility care and the Outcome and Assessment Information Set (OASIS) which assesses home health care, will be incorporated into the CommunityChoice quality strategy as appropriate. DHMH will assess what HEDIS measures Medicare managed care plans already report to CMS in order to promote consistency of quality between the dually eligible and non-dually eligible populations. Examples of HEDIS measures reported by Medicare managed care plans include but are not limited to:

- Colorectal cancer screening;
- Anti-depressant medication management;
- Cholesterol management after acute cardiovascular events; and
- Beta blocker treatment after a heart attack.
-

4.12 DHMH will develop new measures for areas that are specific to CommunityChoice goals, including measures related to the provision of non-medical services in the community.

5 Care Coordination

5.1 DHMH will monitor CCO compliance with requirements for the timeliness of initial and ongoing CCO care coordination activities.

5.2 CCOs shall implement systematic methods of monitoring their case management programs as part of their UM Plans. CCOs shall aggregate and analyze the results and describe

strategies taken to resolve any identified deficiencies. This information shall be made available upon request by DHMH.

5.3 DHMH will review the content of a sample of care plans for access, quality, and enrollee involvement in care planning. Such reviews will allow for monitoring of services, accounting for the flexible and individualized nature of home and community based services. In addition, DHMH will review a sample of medical records to ensure that enrollees receive the services identified in their care plans.

6 Enrollee Satisfaction and Input

6.1 Enrollee experiences with the delivery system and enrollee satisfaction are essential components of ensuring quality in CommunityChoice. In addition to seeking information from enrollees, DHMH will also involve family members and/or informal caregivers, particularly for enrollees with dementia or other cognitive impairments.

6.2 An enrollee satisfaction survey will be administered annually. The survey will address such topics as enrollment and coverage, access to and utilization of health care, communication and interaction with providers, interaction with health plan administration, self-perceived health status, and enrollee demographics. Examples of potential questions are whether enrollees: are treated fairly; have privacy; choose their services and daily routines; choose where and with whom they live; participate in the life of the community; are free from abuse and neglect; and experience continuity and security.

6.3 The survey will be standardized, and to the extent possible will build on nationally accepted survey instruments. However, it will be tailored to the CommunityChoice population. The survey format will assure survey respondents that they will remain anonymous and that there will be no retribution based on negative responses.

6.4 It will be necessary to go beyond traditional mail and phone survey methods to get sufficient response rates and representative samples, particularly for older adults or people with disabilities. Survey questions will need to be sensitive enough to gain accurate assessments, and methods of administration must ensure that responses are unbiased. Early in the survey development, DHMH will hold focus groups with enrollees to get input on survey design.

6.5 In addition to soliciting enrollee input from the survey, each CCO will also be required to have a consumer advisory board to receive regular input from enrollees.

6.6 As discussed in Chapter K, Complaints and Appeals, DHMH will have a CommunityChoice enrollee hotline to enable enrollees to formally express their complaints in a real-time manner and to help them navigate the long term care system.

7 Provider Satisfaction and Input

7.1 DHMH will administer surveys to providers to learn about their experiences and satisfaction with the delivery system. Provider satisfaction surveys will be conducted annually.

7.2 DHMH will have a provider hotline distinct from the enrollee hotline to handle provider inquiries, concerns, and complaints.

7.3 CCOs will have a provider complaint system distinct from that of the enrollee. This will include provider hotlines and policies and procedures for handling inquiries, concerns, and complaints from providers.

7.4 DHMH and CCOs will not take any punitive action against providers for making complaints or appeals against CCOs or DHMH.

8 Quality Review Exemptions

8.1 CommunityChoice CCOs' participation as Medicare Advantage Plans and HealthChoice MCOs (if applicable) will exempt them from some portions of the quality reviews in order to reduce duplication. Instead of requiring a duplicative CommunityChoice review, DHMH and its contractors will use information from Medicare or HealthChoice reviews, as applicable. DHMH will clearly define the portions of the quality reviews which may be produced from Medicare or HealthChoice reviews.

8.2 In these cases, DHMH will obtain HealthChoice review information from the most recent quality review and Medicare Advantage information from the most recent Medicare review.

8.3 The full CommunityChoice quality strategy will still be implemented for CCOs participating as HealthChoice MCOs or Medicare Advantage plans. Because of the different services covered by HealthChoice, Medicare, and CommunityChoice, CCOs will never be fully exempt from quality reviews. For example, because augmented community support services are covered only by CommunityChoice, CCOs will not be exempt from any reviews relating to augmented community support services. Exemptions will serve only to prevent the same thing (such as enrollee rights standards) from being reviewed twice.

K. Complaints and Appeals

1 Introduction and General Requirements

1.1 Enrollees, their representatives, or providers (including care coordinators) will have multiple avenues through which they can voice any dissatisfaction with CommunityChoice. The different avenues are:

1.1.1 A DHMH-run CommunityChoice enrollee hotline;

1.1.2 The customer service hotlines at individual CCOs;

1.1.3 A DHMH-run CommunityChoice provider hotline; and

1.1.4 Provider hotlines at individual CCOs.

1.2 DHMH maintains the HealthChoice Enrollee Action Line to educate HealthChoice enrollees about HealthChoice, help enrollees who are having trouble getting care, and track complaints. Similarly, DHMH will have a CommunityChoice enrollee hotline to enable CommunityChoice enrollees to get help navigating the long term care system and to formally express their complaints in a real-time manner. As with the HealthChoice Enrollee Action Line, the CommunityChoice hotline will be a toll-free number that operates Monday through Friday, with voicemail for messages after hours. The purpose of the hotline will be to: (1) educate enrollees and answer their questions regarding CommunityChoice; (2) direct enrollees to the CCO staff who can assist with the problem and are charged with addressing enrollee complaints; and (3) refer issues that cannot be resolved by the hotline to complaint resolution within DHMH.

1.3 DHMH will review the policies and procedures CCOs have in place for handling enrollee and provider complaints and appeals. CCOs will monitor the documentation and timely resolution of enrollee and provider complaints and appeals. CCO and DHMH complaint and appeals systems will meet State and federal requirements.

1.4 Enrollee representatives or providers acting on behalf of enrollees may access the complaint, appeal, and fair hearing processes for enrollees.

1.5 Enrollees may complain or appeal directly to DHMH at any time. They do not have to first exhaust the CCO complaint and appeal process.

1.6 Complaints must be documented and resolved as expeditiously as the enrollee's health condition requires, but no later than the timeframes established by State and federal requirements.

1.7 Enrollees will be notified at the time of enrollment about DHMH's CommunityChoice hotline, and about their rights in the complaint, appeal, and State fair hearing processes.

1.8 DHMH and CCOs will keep records of complaints and appeals. DHMH will share relevant findings with OHCQ.

1.9 DHMH and CCOs will not take any punitive action against enrollees, providers, or care coordinators for making complaints or appeals against CCOs or DHMH.

2 CCO Enrollee Complaint and Appeal Process

2.1 In the case of a denial, termination, or reduction of benefits, an enrollee may file a complaint or an appeal with a CCO.

2.1.1 The appeal may be filed orally or in writing. For oral appeals, DHMH will require CCOs to record in writing basic information about the request, such as date made, appellant's name, and brief description of the denial, termination, or reduction of benefits being appealed.

2.2 An enrollee may also file a complaint to express dissatisfaction about any matter other than a denial, termination, or reduction of benefits. Outcomes of these complaints are not subject to appeals or State fair hearings.

2.3 Ultimate authority for CCO denial, termination, or reduction of benefits lies with CCOs' Medical Directors. Denials may be appealed to DHMH.

3 CCO Notice of Denial, Termination, or Reduction of Benefits

3.1 If a CCO denies, terminates, or reduces benefits, the CCO must send a notice to the enrollee.

3.2 The notice must be:

3.2.1 Written in language that is easy to understand;

3.2.2 Available in alternative formats that take into account special needs (e.g., vision impairment);

3.2.3 Available in languages other than English;

3.2.4 Available in oral interpretation; and

3.2.5 Information regarding low cost or free legal services.

3.3 The notice must explain the following:

3.3.1 The denial, termination, or reduction of benefits the CCO or its contractor has taken or intends to take;

3.3.2 Reasons for the denial, termination, or reduction of benefits;

3.3.3 Contact information for the CCO and the DHMH CommunityChoice hotline and procedures for exercising appeal and fair hearing rights;

3.3.4 Circumstances under which expedited resolution is available and how to request it; and

3.3.5 Circumstances under which an enrollee has the right to have benefits continue pending resolution of the appeal, and how to request that benefits be continued.

3.3.6 Other information consistent with DHMH and federal requirements.

3.4 The CCO must also notify the service provider.

3.5 The CCO must mail the notice within the timeframes established by DHMH and consistent with federal requirements.

4 Timeframes for CCO Appeals Process

4.1 The timeframe for standard resolution of an appeal and notice to the affected parties is as follows:

4.1.1 Emergency medically related appeals shall be resolved in no more than 24 hours;

4.1.2 Non-emergency medically related appeals shall be resolved within 14 days; and

4.1.3 Administratively related appeals shall be resolved within 30 days.

4.2 The timeframe can be extended if the enrollee requests the extension, or if the CCO demonstrates the need for additional information, and the delay is in the enrollee's interest. For any extension not requested by the enrollee, the CCO must give the enrollee written notice of the reason for the extension.

5 Requirements for CCO Handling of Appeals

5.1 In handling appeals, each CCO must meet the following requirements:

5.1.1 Give enrollees reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

5.1.2 Acknowledge receipt of each appeal.

5.1.3 Ensure that the individuals who make decisions on appeals were not involved in any previous level of review or decision-making; and are health care professionals unless the appeal relates to purely administrative issues.

5.1.4 The appeals process must provide the enrollee or the enrollee's representative with a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The CCO must inform the enrollee of the limited time available for this in the case of expedited resolution.

5.1.5 The appeals process must provide the enrollee opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.

5.1.6 The appeals process must include, as parties to the appeal, the enrollee or his or her representative.

6 Results of CCO Appeals

6.1 The CCO must provide written notice to the enrollee of the result of all appeals. The written notice of the resolution must include the following:

6.1.1 The results of the resolution process and the date it was completed; and

6.1.2 For appeals not resolved wholly in favor of the enrollees, the right to request a State fair hearing, and how to do so; and the right to request to receive benefits while the hearing is pending, and how to make the request.

6.2 If the CCO reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the CCO must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires.

6.3 If the CCO reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the CCO must pay for those services, in accordance with DHMH policy and regulations.

7 DHMH Enrollee Complaint and Appeal Process

7.1 DHMH will operate a complaint and appeal process that is accessible through the CommunityChoice enrollee hotline.

7.1.1 The hotline will have the capability of addressing callers in multiple languages through bilingual staff or the use of a language line service.

7.1.2 The hotline will use an automated system for logging, tracking and resolving enrollee complaints. Information will be analyzed periodically to determine if specific interventions with CCOs are required or changes in DHMH policies and procedures are necessary.

7.2 Cases may be referred to the Ombudsman Program.

7.3 DHMH will have an internal complaint resolution unit to handle complaints and appeals that require extensive investigation or clinical expertise.

7.4 DHMH will agree or disagree with the determination of the CCO to deny, reduce, or terminate the benefit.

7.5 DHMH will take final administrative action on appeals within 90 days from the date the enrollee filed the first appeal, whether that is with the CCO or directly with DHMH. This

will not act as a barrier to emergency care. As stated above in 4.1.1, CCOs will be required to resolve emergency medically-related appeals in no more than 24 hours.

8 Ombudsman Program

8.1 DHMH will have an Ombudsman Program. The Ombudsman Program will be responsible for the following activities:

8.1.1 Educating enrollees about the services provided by CCOs and the enrollees' rights and responsibilities in receiving services from CCOs;

8.1.2 Reporting to DHMH the resolution of disputes, a CCO's failure to meet the State's requirements, and any other information that DHMH may specify;

8.1.3 Facilitating coordination between CCOs and providers to coordinate plans of care that meet enrollees' needs;

8.1.4 Investigating disputes between enrollees and CCOs; and

8.1.5 Advocating on behalf of the enrollee before the CCO, including assisting the enrollee in using the CCO's complaint system.

8.2 DHMH will work with State and local agencies to determine the best method for administering the Ombudsman Program.

9 State Fair Hearings

9.1 An enrollee may appeal a DHMH decision that agrees with a CCO's determination to deny, terminate, or reduce benefits. The enrollee may request a State fair hearing within the timeframe established by DHMH and consistent with State and federal requirements.

9.2 Enrollees will be advised of their right to special accommodations such as reimbursement for expenses of transportation to the hearing and childcare during the hearing.

9.3 A neutral party who was uninvolved with the appeal decision makes the State fair hearing determination.

9.4 The parties to the State fair hearing include the CCO as well as the enrollee or his or her representative.

9.5 If the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the CCO must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires.

9.6 If the State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, DHMH must pay for those services, in accordance with DHMH policy and regulations.

10 Continuation of Benefits Pending Resolution of Appeal or State Fair Hearing

10.1 The CCO must continue the enrollee's benefits pending resolution of the appeal or the State fair hearing if:

10.1.1 The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; and

10.1.2 The services were ordered by an authorized provider; and

10.1.3 The original period covered by the original authorization has not expired; and

10.1.4 The enrollee filed the appeal on or before the later of ten days from when the CCO mailed the notice, or the intended effective date of the CCO's proposed denial, termination, or reduction of benefits; and

10.1.5 The enrollee requests extension of benefits within ten days of notification of the denial, termination, or reduction of benefits.

10.2 Benefits must be continued until:

10.2.1 The enrollee withdraws the appeal;

10.2.2 Ten days after the CCO notifies the enrollee of an appeal resolution adverse to the enrollee (unless the enrollee requests a State fair hearing within those ten days);

10.2.3 Until a State fair hearing office issues a decision adverse to the enrollee (in cases where the enrollee requests a State fair hearing); or

10.2.4 The time period or service limits of a previously authorized service have been met.

10.3 In the case where an enrollee files a frivolous appeal and the final resolution of the appeal upholds the CCO's denial, termination, or reduction of benefits in a case, the cost of services furnished while the appeal is pending may be recovered from the enrollee to the extent that they were furnished solely because of the requirements of the appeal process.

10.4 If DHMH orders the CCO to provide the service, and DHMH's decision is overturned, DHMH is responsible for those costs incurred.

11 CCO Provider Complaint System

11.1 Each CCO shall have a complaint system with complaint and appeals processes for providers and care coordinators that is:

11.1.1 Documented in writing;

11.1.2 Disseminated in writing to all CCO providers at the time they join the CCO's provider panel, and at any time upon request;

11.1.3 Linked to the CCO's Quality Assurance Plan; and

11.1.4 Meets standards of and is approved by DHMH.

11.2 Each CCO must include the following elements in its provider complaint system:

11.2.1 Procedures for documenting and responding to provider complaints in a timely fashion;

11.2.2 Notification to the provider of a CCO's determination that affects the provider or the provider's patient, which includes a description of how to file an internal appeal with the CCOs;

11.2.3 Mechanisms to aggregate and analyze complaint data and to use the data for quality improvement; and

11.2.4 A protocol for transmitting provider complaint reports and aggregate provider complaint and appeal data to the Department on a periodic basis.

12 DHMH Provider Hotline

12.1 DHMH will operate a hotline to handle CommunityChoice provider and care coordinator inquiries and complaints.

12.2 DHMH will establish processes for handling provider complaints.

12.3 DHMH will not review post-service disputes between a provider and a CCO.

12.4 DHMH and CCOs will not take any punitive action against providers and care coordinators for making complaints or appeals against CCOs or DHMH.

13 DHMH CCO Appeal Process

13.1 DHMH will have processes by which CCOs can appeal DHMH decisions.

L. Financing

1 Introduction

1.1 This chapter describes the methodology for developing risk-adjusted capitation payment rates and demonstrates how the waiver will meet budget neutrality requirements.

1.2 The financial goals of the new program are as follows:

1.2.1 Achieve more predictable budgets for the Medicaid program.

1.2.2 Transfer financial risk through fixed, prospective payments. CCOs will assume more financial risk and in turn be given greater flexibility in how the money can be spent, e.g., community-based services.

1.2.3 Reduce the rate of growth in expenditures compared to the current system while promoting a coordinated network of providers responsible for the health of a defined population.

2 Rate Setting and Adjustments

2.1 General approach. Rates paid to CCOs will be initially based on the "fee-for-service-equivalency rate" (FFSER) within the CommunityChoice service areas. That is, the rates will be defined in relationship to the amounts being paid for the covered benefits to the covered population under the existing payment system. There will need to be special adjustments for the population that is dually eligible for both Medicare and Medicaid services, since Medicare is responsible for certain services (e.g., acute care and pharmacy).

2.2 Data preparation. A person-level database has been created that contains recipient demographic information (age, gender, geographic location, eligibility category, level of care status, diagnoses, Medicare coverage) and health care cost information by type of service, including all claims expenditures. In this person-level file, each recipient has a yearly total payment for each service type, e.g., physician, inpatient, outpatient, personal care, pharmacy, home health, and nursing facility care, etc. These total payment variables are based on date of discharge for inpatient episodes, date of dispensing for the pharmacy type, and date of service for all other service types.

2.3 Records of recipients who are not eligible for enrollment in CCOs will be excluded from the analysis as will claims for services that are carved out of the program. Refer to Chapter D, Enrollee Program Participation, for the detailed list of recipients who are eligible for enrollment in CCOs and those who are not.

2.4 In order to account for the total cost of services, claims data will be compared with the CMS-64. The CMS-64 includes expenditures not captured in the claims data. For example, pharmacy claims data will not account for any of the savings realized from drug manufacturer rebates, since rebates are received only after claims have been paid. The difference between claims and actual payments will be added as a percentage to the fee-for-service equivalency rates, accounting for both additions and deletions.

2.5 Populations may be further segmented based on eligibility categories, level of care, and other factors that may predict financial risk. Each person will be assigned to a single risk adjusted category.

Over time, our goal is to evaluate whether it is appropriate to also segment the population, for rate-setting purposes, based on indicators of functional status such as scores from the State's long term care assessment instrument, which incorporates activities of daily living and instrumental activities of daily living. The Department's contractor, University of Maryland Baltimore County, is developing this methodology. This methodology may take a few years to develop, since the measurement of functionality needs to be directly linked to individuals and payments.

2.6 Risk sharing / stop-loss arrangements may be tested. A State self-insured stop-loss arrangement is under consideration. If adopted, fee-for-service payments above the thresholds will be removed from the capitation pool for rate setting. For each person in the database, the total payments, by service provider type will be calculated. The payments will be added up to arrive at the total covered services payment for each person. The resulting total payments for each person will be summed to allocate the total costs and the corresponding average annualized number of eligible persons in the rate cell breakdowns.

2.7 Actuarial models will be used to calculate rates for different groups (duals and non-duals). Medical expense data will be based on fee-for-service payment rates, adjusted for inflation each year. Base year fee-for-service gross payment rates will be adjusted and trended forward to derive the capitation rates for CCO enrollment years. Additional adjustments to the rates will be made for:

2.7.1 Claims lag completion; and,

2.7.2 Adjustments for third party collections.

2.8 Reimbursement rates will be actuarially sound. The UMBC Center for Health Program Development and Management will contract with an actuarial firm to certify the rates.

2.9 CCOs must report financial information to the State on a quarterly basis.

2.10 Rates for new enrollees will be adjusted based on level of care and eligibility category. Once medical expense data has accumulated on an enrollee, they will be risk-adjusted further. The Department needs to closely monitor the expenses of new enrollees.

2.11 The Department will audit and monitor the CCOs' actual expenses annually. The profits and administrative expense allowance will be capped in the capitation rates each year.

2.12 The Department will develop regulations that define the methodology used to calculate CCOs' medical loss ratio and appropriate targets.

2-1 Payments to Providers

2-1.1 CCOs must meet the timely payment requirements established by the Maryland Insurance Administration. CCOs may negotiate payment rates with service providers, with the exceptions listed below.

2-1.2 CCOs will be required to pay not less than the Medicaid-established rates for nursing facility services and comply with the DHMH leave of absence provisions of Health-General § 15-117.

2-1.3 CCOs will be required to pay not less than the Medicaid-established rates for medical day care services.

2-1.4 CCOs will be required to pay the Medicaid-established rates for enrollees who were already regularly receiving assisted living services at the inception of CommunityChoice, unless the provider chooses to negotiate different rates. For these enrollees, CCOs cannot force providers to accept a payment rate different than the Medicaid-established rate.

2-1.5 For enrollees who elect hospice services, the Department will reimburse hospice providers directly for the hospice care at the Medicaid-established rate. For individuals residing in an institution, CCOs will be required to pay for any applicable room and board portion of hospice payments according to federal payment requirements (generally an amount equal to 95 percent of the Medicaid nursing facility rate).

2-1.6 CCOs will pay federally qualified health centers (FQHCs) based on the rate methodology established under the Benefits Improvement and Protection Act (BIPA). CCOs will follow the same alternative payment methodology established under HealthChoice (CCOs will reimburse FQHCs at the BIPA established per visit rate).

2-1.7 For enrollees who have elected coverage under the CCO's Medicare Advantage Plan, the CCO must adhere to Medicare policy when reimbursing for Medicare-covered services.

2-1.8 CCOs must reimburse hospitals in accordance with the rates established by the Health Services Cost Review Commission.

3 Payments and Funding

3.1 Flow of Funds Mechanisms. CCOs will be paid a monthly capitation rate, which will be paid prospectively before the first of each month. The Department will take back capitation rates paid on behalf of participants whose eligibility is cancelled.

3.2 Federal Financial Participation. Federal Financial Participation rate is assumed to remain the same for the waiver population as it currently is for the fee-for-service Medicaid program.

3.2.1 Federal financial participation is requested for each individual determined eligible for the waiver, at the same rate as in the fee-for-service program.

3.2.2 Administrative costs are matched at the regular FMAP rate for administrative expenses.

3.2.3 Medicaid spending by other agencies is based on the regular matching rate.

4 Cost Estimation

4.1 Below is an illustration of how the cost and savings estimations will be presented. Note: DHMH cost estimates assume that the approval is granted to continue and to expand CommunityChoice statewide after 2008.

Cost Estimates With Waiver

Fiscal Year	Total Expenditures	Average No. of Enrollees	Cost Per Enrollee
2001	$ 559,194,947	34,544	$ 16,188
2002	$ 633,861,962	35,724	$ 17,743
2003	$ 704,220,172	36,344	$ 19,377
2004	$ 779,555,019	36,180	$ 21,547
2005	$ 850,534,035	36,661	$ 23,200
2006	$ 947,206,587	37,210	$ 25,455
2007	$ 1,102,822,805	37,769	$ 29,199
2008	$ 1,190,282,590	38,335	$ 31,049
2009	$ 1,624,620,340	49,027	$ 33,137
2010	$ 2,135,759,621	60,031	$ 35,578
2011	$ 2,771,342,480	72,155	$ 38,408

Cost Estimates Without The Waiver

Fiscal Year	Total Expenditures	Average No. of Enrollees	Cost Per Enrollee
2001	$ 559,194,947	34,544	$ 16,188
2002	$ 633,861,962	35,724	$ 17,743
2003	$ 704,220,172	36,344	$ 19,377
2004	$ 779,555,019	36,180	$ 21,547
2005	$ 850,534,035	36,661	$ 23,200
2006	$ 947,206,587	37,210	$ 25,455
2007	$ 1,047,487,921	37,769	$ 27,734
2008	$ 1,159,336,304	38,335	$ 30,242
2009	$ 1,617,648,939	49,027	$ 32,995
2010	$ 2,163,439,811	60,031	$ 36,039
2011	$ 2,843,501,103	72,155	$ 39,408

M. Evaluation and Reporting

1 Introduction

1.1 This chapter describes the Department's plan for evaluating CommunityChoice, what data will be available to evaluate CommunityChoice and how the Department will meet the reporting requirements of the Medicaid program.

2 Evaluation

2.1 The Department will evaluate CommunityChoice on an ongoing basis by reviewing a range of areas, including health outcomes, access to care, utilization of services, CCO networks, enrollee and provider satisfaction, and CCO systems performance to determine how well CommunityChoice goals are being met. Many of these areas will be reviewed as part of the Quality strategy. While the quality strategy will assess the performance of individual CCOs, the evaluation efforts will focus on the success of CommunityChoice performance as a whole. The CommunityChoice Advisory Group and an independent panel of experts will assist the Department in identifying key evaluation measures.

2.1.1 The evaluation will focus on certain measures, for example, the percent of enrollees using community services versus long term care services, rates of hospitalizations, and ER utilization, .

2.1.2 The Department will look at baseline performance on key measures in order to compare performance prior to the implementation of CommunityChoice with performance under CommunityChoice.

2.2 The Department will provide an annual review of CommunityChoice that summarizes CommunityChoice performance in a variety of areas.

2.3 After the first year of operation, the Department will conduct a comprehensive evaluation of the CommunityChoice pilot program. The Department will convene an independent panel of experts to assist in designing and executing the comprehensive evaluation. The evaluation will examine the success of the pilot program in order to inform decisions about the continuation and statewide expansion of the program.

3 Data for Evaluation

3.1 The Department will use a variety of data sources to evaluate CommunityChoice.

3.2 CCOs will be required to provide certified complete and accurate encounter data in standard formats for every enrollee. The Department will build upon its current experience in obtaining encounter data from managed care plans in HealthChoice to assure that complete CCO encounter data are available.

3.2.1 CCOs will submit encounter data monthly for all encounters.

3.2.2 CCOs will use automated systems to submit encounter data. The Department will specify minimum acceptable capabilities of a CCO's automated system.

3.2.3 The Department may provide encounter data technical assistance to CCOs as appropriate.

3.2.4 The Department will conduct focused medical record reviews to supplement encounter data in the early years of CommunityChoice as the encounter data set is developing.

3.3 Maryland will analyze other available data as appropriate (e.g., fee-for-service claims data, HEDIS, Medicare data, Minimum Data Set [MDS], and other quantitative or qualitative data [e.g., surveys, focus groups]) to complement CCO encounter data.

3.4 CCOs will be required to demonstrate capability to comply with all data requirements prior to the implementation of CommunityChoice and thereafter.

3.5 The submission of timely, accurate data will be required. The Department may take corrective action for late, incomplete, or inaccurate data submissions.

4 Reporting

4.1 Maryland's Medicaid Management Information System (MMIS) will meet regular CMS reporting requirements.

4.2 Maryland will submit quarterly status reports to CMS summarizing accomplishments and describing developments in key areas of the waiver.

4.3 Maryland will submit quarterly expenditure reports to CMS with no change in basic format.

4.4 The Department will prepare a variety of regular reports on the implementation and effectiveness of the CommunityChoice comprehensive quality strategy to ensure continuous improvement. The reports will take into account the seven dimensions of the CMS Home-and Community-Based Services quality framework, and may include:

4.4.1 Evaluation of enrollees' access to care and utilization of services (e.g., through encounter data analyses and HEDIS);

4.4.2 Enrollee-centered service planning and delivery, including evaluations of CCOs' adherence to care plan standards and quality of care standards in the consumer-directed option;

4.4.3 Provider capacity and capabilities, based on CCOs' compliance with access and credentialing standards;

4.4.4 Outcomes measurements to ensure appropriate enrollee safeguards are taken (e.g., monitoring incidence of pressure-induced bed sores, falls, etc.);

4.4.5 Results of consumer satisfaction surveys;

4.4.6 Results of provider satisfaction surveys:

4.4.7 Systems performance review;

4.4.8 Summary record of grievances, hotline calls, and appeals;

4.4.9 CCO performance improvement project (PIP) reports;

4.4.10 Consumer report card to describe CCO performance based on a variety of quality indicators;

4.5 CCOs will regularly submit financial reports, including:

4.5.1 Financial monitoring reports; and

4.5.2 Annual financial filings with the Maryland Insurance Administration.

4.6 The Department will conduct CCO financial audits on a regular basis and will compile a report summarizing the audit findings.

4.7 The Department will provide an annual summary report on CommunityChoice performance, and will offer to brief key stakeholders, including legislators, the Medicaid Advisory Committee, consumer representatives, and provider groups on the contents of the report. The report will be available on the DHMH website.

N. Waivers

1 Introduction

1.1 This chapter describes each section of title XIX of the Social Security Act (SSA) for which a waiver is being requested and the rationale for requesting that the section be waived.

1.2 The State requests that CMS approve waiver under section 1115(a)(1) and (a)(2) of the SSA.

2 Sections to be waived under section 1115(a)(1)

2.1 Comparability (Amount, Duration, and Scope) – Section 1902(a)(10)(B) To enable the State to modify the Medicaid benefit package and to permit coverage of benefits for waiver eligibles which are not covered for non-waiver eligibles.

2.2 Statewideness – Section 1902(a)(1) To enable the State to permit non-waiver eligibles to receive current Medicaid benefits whereas demonstration recipients will receive modified services.

2.3 Freedom of Choice – Section 1902(a)(23) To enable the State to restrict the freedom of choice of provider. Waiver eligibles will choose among at least two CCOs and be restricted to services within the selected CCO.

2.4 Institutional Income and Resource Rules – Section 1902(a)(10)(C)(i)(III) To apply institutional income and resource rules for the medically needy waiver population.

3 Sections to be waived under section 1115(a)(2)

3.1 Expenditures – Under the authority of section 1115(a)(2) of the SSA, the State requests that expenditures for the items identified below (which are not otherwise included as expenditures under section 1903) shall, for the period of the project, be regarded as expenditures under the State's title XIX plan:

3.1.1 Expenditures to provide the matching authority required to capitate the Medicaid-only CCOs for a comprehensive package of services and to enable the state's Medicaid/Medicare membership in a managed care entity to exceed 75 percent of total enrollment.

3.1.2 Expenditures to enable the state to "lock-in" waiver eligibles to a CCO for 12 month intervals, with the ability to remove individuals from the CCO sooner "for cause" as outlined in this waiver application.

3.2 Recipient Income and Resources – Section 1903(f)(4) To apply the 1902(r)(2) rules for consideration of income and resources for SSI-related populations to the waiver population.

Chapter J Appendix: Qualifications of External Quality Review Organizations (EQROs)

1 The EQRO will be a federally approved quality improvement organization (QIO).

2 The EQRO must have at a minimum the following competencies:

- Staff with demonstrated experience and knowledge of Medicaid beneficiaries, policies, data systems, and processes; managed care delivery systems, organizations, and financing; quality assessment and improvement methods; and research design and methodology, including statistical analysis.
- Sufficient physical, technological, and financial resources to conduct EQR or EQR-related activities.
- Other clinical and non-clinical skills necessary to carry out EQR or EQR-related activities and to oversee the work of any subcontractors.

3 The EQRO and its subcontractors must be independent from DHMH and the CCOs.

4 An EQRO may not:

- Review a particular CCO if either the EQRO or the CCO exerts control over the other through stock ownership; stock options; voting trusts; common management, including interlocking management; and contractual relationships.
- Deliver any health care services to Medicaid beneficiaries;
- Conduct, on the State's behalf, ongoing Medicaid managed care program operations related to oversight of the quality of CCO services, except for the EQRO-related activities; or
- Have a present, or known future, direct or indirect financial relationship with a CCO that it will review as an EQRO.

5 The EQRO(s) may use subcontractors. The EQRO is accountable for, and must oversee, all subcontractor functions. Subcontractors must also meet requirements for independence.

6 Each EQRO contract will follow an open, competitive procurement process in accordance with State and federal law and regulations.